Integrative Medicine Intake Form

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The practice of Integrative Medicine requires the understanding of clients as a whole: mind, body, and spirit. Please take the time to fill out this intake form as completely as possible. This form will provide a foundation for your experience with us, as it will help to stimulate areas that may need special attention during your visit. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing, but wish to discuss in-person, we may do so at your appointment.

Name: ______________________________ **Date of Birth**:____________

Today's Date:____________

Referral Source: ☐ Physician: ______________ ☐ Self ☐ Other : ____________

Primary Care Physician: ______________________________

Goals: Please list the reasons you have chosen to see our Integrative Medicine Provider. What are your major expectations?

____

____

How would you describe your **current state of health**? (poor, fair, good, excellent): ______________

____

____

Past Medical History: Check all that apply and fill in any not listed at the end.

☐ Allergies
☐ Alzheimer's
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clot(s)
☐ Breast Disease
☐ Broken Bone
☐ Cancer (Type:)
☐ Chronic Fatigue
☐ Chronic Pain
☐ Chronic Sinusitis
☐ Depression
☐ Diabetes
☐ Diarrhea
☐ Diverticulitis
☐ Eczema
☐ Emphysema
☐ Endometriosis
☐ Fibromyalgia
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Hypothyroidism
☐ Impotence
☐ Irritable Bowels
☐ Kidney Disease
☐ Low Testosterone
☐ Menopause
☐ Migraines
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Panic Disorder
☐ Prostate Enlargement
☐ Reflux (GERD)
☐ Seizures
☐ Stroke
☐ Urinary Tract Infection
☐
☐
☐

Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

- ☐ Appendix__________
- ☐ Gall Bladder________
- ☐ Tonsils__________
- ☐ Sinus Surgery_______
- ☐ Tubes in Ears_______
- ☐ Hysterectomy_______
  Check One: ☐ Total ☐ Partial
- ☐ Tubal Ligation________
- ☐ Cardiac Bypass________
- ☐ Catheterization_______
- ☐ Spinal Fusion________
- ☐ Joint Replacement_____
  Which Joint:_________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Review of Current Symptoms: Please check any symptoms or concerns you have had in the last several months.

Constitutional
- ☐ Good general health
- ☐ Recent weight change
- ☐ Headaches
- ☐ Fever

Ear/Nose/Throat
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Eyes
- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Double/blurred vision

Cardiovascular
- ☐ Chest pain or pressure
- ☐ Palpitations
- ☐ Shortness of breath lying flat
- ☐ Swelling of extremities

Respiratory
- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Asthma or wheezing

Energy
- ☐ Forgetful
- ☐ Poor concentration
- ☐ Fatigue – Worst time of day:________

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Painful bowel movement
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Abdominal pain

Hematology
- ☐ Bleeding or bruising
- ☐ Anemia
- ☐ Past transfusion

Genitourinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Change in force of urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Male-testicle pain
- ☐ Female-irregular menses

Neurological
- ☐ Frequent headaches
- ☐ Light-headed/dizzy
- ☐ Convulsions
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Head injury

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weak muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty in walking

Skin/Breast
- ☐ Cold hands or feet
- ☐ Hives
- ☐ Rash or itching
- ☐ Hair loss
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump

Psychiatric
- ☐ Memory loss/confusion
- ☐ Nervousness/Anxiety
- ☐ Depression/Mania
- ☐ Addictive behavior

Endocrine
- ☐ Excessive thirst/urination
- ☐ Sugar cravings
- ☐ Hot/cold intolerance
- ☐ Poor sex drive
- ☐ Dry skin

Sleep
- ☐ Problems falling asleep
- ☐ Problems staying asleep
- ☐ Snore
- ☐ Restless legs

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member(s) in the space provided):

- ☐ Alcoholism____________________
- ☐ Allergies____________________
- ☐ Alzheimer's____________________
- ☐ Anemia ____________________
- ☐ Asthma ____________________
- ☐ Birth Defect____________________
- ☐ Bleeding Disorder____________________
- ☐ Cancer____________________
  - Member/Type:____________________
  - Member/Type:____________________
  - Member/Type:____________________
- ☐ Depression____________________
- ☐ Diabetes____________________
- ☐ Epilepsy____________________
- ☐ Heart Disease____________________
- ☐ High Blood Pressure____________________
- ☐ High Cholesterol____________________
- ☐ Kidney Disease____________________
- ☐ Stroke____________________
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Allergies:

Are you aware of any drug allergies? ☐ Yes ☐ No

If yes, please list the drugs and the reaction you had:____________________

____

____

____

Environmental allergies?

____

____

Food allergies?

____

____

Social History:

Who lives at home with you?____________________

____

Who are the people, including members of your family, who play a very important role in your life?

Name	Relationship to you	Age	Where do they live?

Social History (cont'd):

Are you satisfied with your personal relationships? ☐ Yes ☐ No

How would you describe your household? Circle all that apply.

Open	Loving	Happy	Mellow	Dull	Frustrating
Tense	Chaotic	Crazy	Safe	Enjoyable	Suffocating
Supportive	Interesting	Predictable	Frightening	Secretive	Unhappy

Do you have any concerns about your current living situation?

☐ Yes ☐ No If yes, please explain: ____________________

____

____

Do you have any concerns about your current financial situation?

☐ Yes ☐ No If yes, please explain: ____________________

____

____

If you are a parent, do you have any concerns about parenting? ☐ Yes ☐ No

Do you consider yourself heterosexual, homosexual, bisexual, transgender, other? ____________

Have you, or a close family member, ever experienced sexual abuse or assault?

☐ Yes ☐ No If yes, please explain: ____________________

____

____

Do you use any form of birth control or protection from sexually transmitted infections?

☐ Yes ☐ No If yes, please describe: ____________________

____

____

Are you satisfied with your sexual relationships?

☐ Yes ☐ No If no, please explain: ____________________

____

____

Are you currently a student? ☐ Yes ☐ No

How many years of education have you completed? ____________

Social History (cont'd):

Do you have any difficulties with learning? ☐ Yes ☐ No If yes, please describe: ______________

____

____

Overall, do you feel that you get enough sleep? ☐ Yes ☐ No

What time to you go to bed? ________________

What time do you wake up? ________________

Are you tired or sleepy during the day? ☐ Yes ☐ No

Do you take any medications or OTC products to help you sleep? ☐ Yes ☐ No

If yes, what do you take? ____

Do you snore? ☐ Yes ☐ No

What is your job or occupation? ____

Are you satisfied with your work? ☐ Yes ☐ No

Please describe your job duties, approximately how many hours per week and any concerns you may have about your job: ____

____

____

Is there anything about your work that negatively affects your mental or physical health? ______________

____

Has this, or any job, put you around strong chemicals or smoke? ☐ Yes ☐ No

Tobacco: ☐ Yes ☐ No If Yes, how many per day: ____________ How many years: ____________

Currently smoking: ☐ Yes ☐ No If quit, how long ago: __________

Smoke exposure at home: ☐ Yes ☐ No

Alcohol: ☐ Yes ☐ No If Yes, how many drinks per week: _____ How many years: ____________

Drug Use (state which drug and if currently using): ____

Please list your current hobbies/interests: ____

____

____

____

Do you have any acute or chronic pain? ☐ Yes ☐ No If yes, please explain: ______________

____

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____

Stress: Stress and the management of stress is very important to your overall health.

Describe the symptoms that you feel when you are under stress:________________________________

Describe activities or techniques you use to relieve stress:________________________________

What are the greatest sources of comfort in your life? ________________________________

Spiritual Life: Having an active spiritual or religious life is an important part of your overall health.

Do you belong to an organized religion or spiritual group? ☐ Yes ☐ No

If yes, describe your current religious practice (Please provide details as to how often and what you do. For example, do you attend church or other ceremony? Any small group study?):________________________

Medications: Please attach a separate list if you have one, or if you need extra space.

Name	Dose	How Often? (if as needed, state average use)

Supplements: Please be as specific as possible. In addition to listing, please bring all supplements to your appointment.

What Is It	Manufacturer	Dosage	How Many Per Day	Why You Take It

Dietary Information:

What foods do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant?______

Please provide honest answers to these questions based on a typical day:

Cups of regular coffee:________ Regular soda:________ Flavored water or Propel:_____

Cups of decaf coffee:_________ Diet soda:___________ Meals per day:_____________

Cups of regular tea:__________ Crystal Light:________ Meals made at home:________

Cups of decaf tea:___________ Artificial Sweetener packs (Splenda or others):_______

How many servings of fruits and vegetable to do eat per day? ________________________________

Dietary Information (cont'd):

Are you currently on a special diet? ☐ Yes ☐ No If yes, please explain:______________________

____

What is your fluid intake on a typical day? ____

What is your relationship with food? ____

____

What is your desirable weight? ____

Have there been any recent changes in diet intake or weight? ☐ Yes ☐ No

If yes, please explain:____

____

Have you made any changes recently in your eating habits because of your health? ☐ Yes ☐ No

If yes, please explain:____

____

Do you feel in control of your eating habits? ☐ Yes ☐ No

Do you obsess about food, weight, or body image? ☐ Yes ☐ No

Exercise: Please answer the following questions based on an average week.

How many times per week do you exercise?_________________

List the specific exercises that you do, and how long you typically do them:

Exercise	Duration
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Previous Complimentary Experiences:

- ☐ Acupuncture
- ☐ Art Therapy
- ☐ Ayurvedic Medicine
- ☐ Biofeedback
- ☐ Breath Work
- ☐ Chiropractic
- ☐ Dance (movement therapy)
- ☐ Guided Imagery
- ☐ Healing Touch
- ☐ Homeopathy
- ☐ Hypnotherapy
- ☐ Iridology
- ☐ Massage
- ☐ Meditation
- ☐ Music Therapy
- ☐ Naturopathy
- ☐ Osteopathy
- ☐ Psychological Counseling
- ☐ Qi Gong
- ☐ Reflexology
- ☐ Reiki
- ☐ Somatic Experience
- ☐ Stress Reduction Techniques
- ☐ Tai Chi
- ☐ Yoga
- ☐ Other: ____________________

Preventative Services: Please list the date of your most recent screening procedures.

Breast Cancer:	Mammogram	____________________
Cervical Cancer:	Pap Smear	____________________
	Colposcopy	____________________
Colon Cancer:	Colonoscopy	____________________
	Three stool test	____________________
Prostate Cancer:	PSA	____________________
	Digital rectal exam	____________________
Diabetes:	Fasting blood sugar	____________________
Heart Disease:	Fasting lipid panel	____________________
Osteoporosis:	DEXA scan	____________________
Carotid Artery Disease:	Carotid Doppler	____________________

Is there any other information you feel is important?

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Thank you for taking the time to complete this intake form,

Dr. Escobar

Diet Recall of Previous 24 hours: Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages, and condiments.

Food Item	Preparation (baked, fried, etc)	Amount (cup, tbs, oz, etc)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		