Integrative Medicine – MD_ND_RD New Patient Form

Date of Initial Visit: _____ **Patient MRN:** _____

Integrative Medicine's ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinicians during your consultations. * This is a **confidential** questionnaire *

First Name: _____ **Middle Name:** _____ **Last Name:** _____

What sex were you assigned at birth? _____ **How would you like to be addressed?** _____

What is your current gender identity? _____ **Preferred Pronoun?** _____

Date of Birth: _____ **Age:** _____ **Marital Status:** _____

May we leave a message? Yes: ☐ No: ☐

Email Address: _____

Would you like to be added to the Integrative Medicine newsletter? Yes: ☐ No: ☐

May your practitioner contact you periodically by email? Yes: ☐ No: ☐

Primary Care Physician: _____ **Referred By:** _____

Emergency Contact & Mobile Number: _____

What aspects of your health are most important to address at this time? List your health concerns in order of importance:

Priority 1: _____ Priority 3: _____

Priority 2: _____ Priority 4: _____

Social History

Alcohol Consumption Type: _____ How many? _____ Frequency: _____

Tobacco Use

Do you use tobacco? Cigarettes Cigars Smokeless Spitless Waterpipe Vape

How many/much? _____ Frequency? _____

Age when started? _____ If you quit, when? _____

Recreational Drug Use What? _____ Frequency? _____

Age when started? _____ If you quit, when? _____

Cannabis/Marijuana: Form? _____ Frequency? _____

Age when started? _____ If you quit, when? _____

Name: _____ **Date of Birth:** _____

Social History (continued)

Name some positive elements in your life:

1: _____ 3: _____

2: _____ 4: _____

What brings you joy? _____

Religion/Spirituality

Do you engage in regular prayer or meditation? _____

Relationships

Are you in a supportive relationship? Yes: ☐ No: ☐ Are you in a relationship you would like to change? Yes: ☐ No: ☐

Do you feel safe in your home? Yes: ☐ No: ☐ Do you have someone that you can confide in? Yes: ☐ No: ☐

Have you ever been physically, emotionally, or sexually abused? Yes: ☐ No: ☐

If you are experiencing physical, emotional, or sexual harm from someone, please talk to me so that I can help.

Education/Employment

What level of education did you complete? _____ Are you currently employed? Yes: ☐ No: ☐

Employer's Name: _____ Occupation: _____

List current medications (including non-prescription) along with dose and frequency.

	Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Name: _____ **Date of Birth:** _____

List all vitamins, minerals, and other nutritional supplements that you are currently taking along with dose and frequency (indicate mg or IU).

	Vitamin/Mineral/Supplement	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Allergies: List any medications that you are allergic to and your body's reaction.

	Medication	Reaction
1.		
2.		
3.		

Digestion/Nutrition

Do you follow any special diet? Vegan Vegetarian Mediterranean Anti-Inflammatory Paleo Ketogenic

Other: _____

Do you develop any symptoms after eating certain foods? _____

How much water do you drink per day? _____ How much caffeine do you consume per day? _____

Do you use artificial sweeteners? Yes: ☐ No: ☐ If yes, which ones? _____

Bowel Movements: How often: _____ Color: _____ Consistency: _____

Has your weight been stable? Yes: ☐ No: ☐

Please complete a Diet ID food survey prior to your appointment: **https://corewellhealth.dietid.com/**

Exercise/Movement

Do you exercise regularly (cardio, strengthening, yoga, etc)? Yes: ☐ No: ☐

Type of exercise: _____ Frequency: _____

Type of exercise: _____ Frequency: _____

How do you feel after exercise? _____

Name: _____ **Date of Birth:** _____

Sleep/Relaxation

Do you have? Sleep apnea ☐ Trouble Falling Asleep ☐ Trouble Staying Asleep ☐

How many hours of sleep do you get per night? _____ What time do you usually fall asleep? _____

Do you experience sleepiness during the day? Yes: ☐ No: ☐ Do you take naps? Yes: ☐ No: ☐

Do you awaken refreshed? Yes: ☐ No: ☐

Energy Level

How is your energy level? _____

Energy best at what time of day? _____

Stress/Resilience

Any significant life changes recently? Yes: ☐ No: ☐ If yes, explain: _____

Does your stress level interfere with your enjoyment of life, your sleep, or your relationship? _____

_____

How do you manage stress? _____

Sexual/Reproductive Health

Women's Health

Age when started period: _____ Last menstrual period: _____

# of Pregnancies: _____ # of Live Births: _____

Any hormone replacement? Yes: ☐ No: ☐ _____

Any problems related to menstrual cycles? Breasts, uterus, or ovaries? _____

_____

Men's Health

Date of most recent prostate check-up? _____ PSA results? _____

Please check the box next to all that apply

Erectile Dysfunction ☐	Decreased Libido ☐	Urinary Pain ☐	Dribbling ☐
Difficulty with Urination ☐	Increased Libido ☐	Start/Stop ☐	Up at Night ☐

Infertility Issues? Yes: ☐ No: ☐ _____

Name: _____ **Date of Birth:** _____

Review of Systems Checklist

Please indicate if you have had any of the below symptoms in the past 7 days

Constitutional/General		
Fever	Yes	No
Difficulty Managing Weight	Yes	No
Food Cravings	Yes	No
Poor Appetite	Yes	No
Binge Eating/Drinking	Yes	No
Fatigue	Yes	No
Restlessness	Yes	No
General Weakness	Yes	No
Low Stamina	Yes	No
Skin/Nails		
Rash	Yes	No
Acne	Yes	No
Vitiligo	Yes	No
Rosacea	Yes	No
Eczema	Yes	No
Psoriasis	Yes	No
Itching	Yes	No
Hives	Yes	No
Thin/Cracking/Peeling Nails	Yes	No
Nail Fungus	Yes	No
Discolored Nails	Yes	No
Nails with Ridges	Yes	No
Nails with Pits	Yes	No
Cardiovascular		
Chest Pain	Yes	No
Hypertension	Yes	No
Palpitations	Yes	No
Rapid Heart Rate	Yes	No
Slow Heart Rate	Yes	No
Leg or Foot Swelling	Yes	No
Respiratory		
Cough	Yes	No
Cough Up Blood	Yes	No
Wheezing/Asthma	Yes	No
COPD	Yes	No
Difficulty Breathing	Yes	No
Shortness of Breath	Yes	No
Allergy/Immune		
Hepatitis	Yes	No
HIV+	Yes	No
Food Allergies	Yes	No
Environmental Allergies	Yes	No
Frequent Infections	Yes	No

Eyes		
Watering	Yes	No
Itching	Yes	No
Dryness	Yes	No
Redness	Yes	No
Drainage	Yes	No
Bags Under Eyes	Yes	No
Dark Circles	Yes	No
Eyelid Irritation	Yes	No
Change in Vision	Yes	No
Light Sensitivity	Yes	No
Head/Eyes/Ears/Nose/Throat		
Hearing Loss	Yes	No
Ringing in Ears	Yes	No
Ear Pain	Yes	No
Sore Throat	Yes	No
Hoarse Voice	Yes	No
Clearing Throat Often	Yes	No
Canker Sores	Yes	No
Dental Cavities	Yes	No
Gums Sore/Swollen	Yes	No
Tongue Sore	Yes	No
Nasal/Sinus Congestion	Yes	No
Bad Breath	Yes	No
TMJ	Yes	No
Grinding Teeth	Yes	No
Headaches/Migraines	Yes	No
Blurred Vision	Yes	No
Glasses or Contacts	Yes	No
Neurologic		
Seizures	Yes	No
Stroke	Yes	No
Headache	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Difficulty with Balance	Yes	No
Slurred Speech	Yes	No
Numbness/Tingling	Yes	No
Tremor	Yes	No
Memory Loss	Yes	No
Vertigo: spinning, movement sensations	Yes	No

Gastrointestinal/Abdominal		
Reflux	Yes	No
Ulcer	Yes	No
Belching	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Cramping	Yes	No
Abdominal Pain	Yes	No
Poor Appetite	Yes	No
Poor Thirst	Yes	No
Burning Sensation	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Excess Gas	Yes	No
Bloating	Yes	No
Hemorrhoids	Yes	No
Rectal Pain	Yes	No
Mucus in Stool	Yes	No
Blood in Stool	Yes	No
Black Stool	Yes	No
Stool Incontinence	Yes	No
Genitourinary		
Frequency	Yes	No
Pain with Urination	Yes	No
Up at Night to Urinate	Yes	No
Incontinence	Yes	No
Blood in Urine	Yes	No
Genital Discharge	Yes	No
Genital Itching	Yes	No
Low Libido	Yes	No
Erectile Dysfunction	Yes	No
Musculoskeletal		
Joint Pain	Yes	No
Joint Stiffness	Yes	No
Muscle Pain	Yes	No
Muscle Stiffness	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Muscle Cramps	Yes	No
Muscle Twitching	Yes	No

Name: _____ **Date of Birth:** _____

Review of Systems Checklist Continued

Please indicate if you have had any of the below symptoms in the past 7 days

Endocrine/Hematology		
Goiter	Yes	No
Hypothyroid	Yes	No
Blood Clots (DVT)	Yes	No
Easy Bruising	Yes	No
Easy Bleeding	Yes	No
Easily Over Heated	Yes	No
Cold Intolerant	Yes	No
Breast Abnormality	Yes	No
Irregular Periods	Yes	No
Heavy Periods	Yes	No
PMS Symptoms	Yes	No
Frequent Thirst	Yes	No
Sweating/Night Sweats	Yes	No
Hot Flashes	Yes	No
Hair Loss	Yes	No

Psychiatric		
Anxiety	Yes	No
Depression	Yes	No
Hallucinations	Yes	No
Mood Disorder	Yes	No

Name: _____ **Date of Birth:** _____

Medical Health Timeline

The purpose of the timeline is to look at all the physical, mental, and emotional events in your life, to see what impact they may have had on your current health. Circle what applies, and use the lines to add any additional details. We will review at your visit.

Your Birth: Full term/premature Vaginal delivery/C section Feeding: breast/bottle

Childhood (birth-17)

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues, sinus infections, UTI, toxic exposures, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion
- **Surgeries:** Appendectomy, tonsillectomy, orthopedic surgery
- **Emotional Events:** Drug/alcohol use in the house when you were growing up, mental illness of parent or sibling, divorce of your parents, abuse (physical, sexual, emotional), significant losses, bullying, significant moves, pregnancy

Additional Details:

_____

_____

_____

Young adult (18-29)

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues (reflux, constipation, IBS, IBD), sinus infections, UTI, cancer, toxic exposures, diabetes, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, cholecystectomy tonsillectomy, orthopedic surgery
- **Emotional Events:** College graduation, graduate degree, marriage, divorce, childbirth, miscarriage, abortion, significant moves, significant losses, abuse/assault

Additional Details:

_____

_____

_____

Name: _____ **Date of Birth:** _____

Medical Health Timeline (continued)

Adult (30-59)

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues (reflux, IBS, IBD), sinus infections, UTI, cancer, toxic exposures, diabetes, hypertension, stroke, arrhythmia, elevated cholesterol, menopause, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, cholecystectomy tonsillectomy, orthopedic surgery, hysterectomy
- **Emotional Events:** College graduation, graduate degree, marriage, divorce, childbirth, miscarriage, abortion, significant moves, significant losses, abuse/assault, job loss, retirement

Additional Details:

_____

_____

_____

Adult (60+)

- **Illness:** Infections, allergies, asthma, eczema, headaches, digestive issues (reflux, IBS, IBD), sinus infections, UTI, cancer, toxic exposures, diabetes, hypertension, stroke, arrhythmia, elevated cholesterol, neurologic issues, anxiety/depression
- **Injuries:** Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- **Surgeries:** Appendectomy, cholecystectomy tonsillectomy, orthopedic surgery, hysterectomy
- **Emotional Events:** Educational degree, marriage, divorce, significant moves, significant losses, abuse/assault, job loss, retirement

Additional Details:

_____

_____

_____