UC Health Integrative Medicine

UC Health Physicians Office Midtown
3590 Lucille Drive, Suite 2400
Cincinnati, OH 45213

UC Health Physicians Office South
7675 Wellness Way, 4th Floor
West Chester, OH 45069

UC Health Barrett Cancer Center
234 Goodman Street, 2nd Floor
Cincinnati, OH 45219

P (513) 475-9567
F (513) 458-1989

UCHealth.com/Integrative

Dear Valued Patient,

Thank you for your interest in UC Health Integrative and Functional Medicine clinical services. We are glad you are exploring your health care options and look forward to partnering with you to meet your health goals.

Integrative Medicine combines conventional medicine with evidence-based complementary therapies with a focus on healthy lifestyle to address stress, nutrition, movement, sleep and your environment to reduce suffering and promote overall wellness.

Our multi-disciplinary team not only, reviews health concerns that may not have responded well to modern/conventional medical approaches but also, helps patients with preventing diseases they wish to avoid.

Our aim is to help people feel *truly well*. We look forward to your first visit and partnering with you on your wellness!

Before your first visit:

1) **New Patient Questionnaire:**
   - **a.** As we prepare for your visit, we kindly ask that ALL new patients please complete the attached New Patient Questionnaire and send back to us.
     please keep a copy of your paperwork for your records
     - i. You can also visit our website UCHealth.com/Integrative to download a copy.

***** Please Note: New Patient Paperwork is due one week prior to your scheduled appointment. If new patient paperwork is not received within 5 business days, your appointment may be rescheduled. *****
***** Please also note: Patients who send back paperwork in advance will be put on our waiting list and eligible for an earlier appointment time should a patient cancel or reschedule.*****

   - b. You can return you paperwork using any of the methods below:
     -Fax to (513-458-1989)
     -Email (Cheryl.Smith@UCHealth.com)
     - Mail to: *(please allow 10 business days for proper processing)*
     UC Health Integrative Medicine
     Attn: Cheryl Heitfield
     3590 Discovery Drive, Suite 2600
     Cincinnati, OH 45213

2) **Attendance Policy:**
   - a. To better serve you and to assist with our continued focus on customer satisfaction, we have attached our Attendance Policy for your review.
     - i. We ask that you please sign and return with your completed paperwork.

3) **Arrival of First Visit:**
   - **a.** New patients please arrive 30 minutes before your appointment to allow time for registration and welcome to Integrative Medicine.

If you have any questions, feel free to contact us at 475- WLNS (9567) or email: Cheryl.Smith@UCHealth.com.

April 2017

UC Health Integrative Medicine
UC Health Midtown Office
3590 Lucille Drive, Suite 2400
Cincinnati, Ohio 45213
P (513) 475-WLNS (9675)

www.UCHealth.com/Integrative

Demographics and Health History Questionnaire A

In order for us to provide a comprehensive evaluation please complete all information on this intake questionnaire as accurately and completely as possible. All information will be treated as strictly confidential. If you have questions, please consult your Integrative Medicine practitioner or call us at 475-WLNS.

Date: _____ Integrative Medicine Appointment Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Last 4 digits of SS # _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Best Daytime Phone: (_____) _____ Secondary Phone: (_____) _____

Occupation: _____

Emergency Contact Name and Phone: _____

Email address: _____

Please check the appropriate box(es) that most accurately represents your **genetic** background:

☐ African ☐ European ☐ Asian

☐ Native American ☐ Middle Eastern ☐ Other: _____

Educational History: which levels of study have you completed? ☐ Still in school/training

☐ Middle school ☐ High school /Trade school ☐ Two year college ☐ Four year college ☐ Graduate school

Employment: which box(es) apply to you currently?

☐ Paid work 40 or more hrs/week ☐ Paid work less than 40 hrs/week ☐ Volunteer work _____(hrs/week)
☐ Disabled ☐ Fulltime Home maker ☐ Retired

Personal Relationships:

What is your marital status? Single ☐ Married ☐ When?_____ Long term partnership ☐ Since when?_____
Divorced ☐ When?_____ Widowed ☐ When?_____

With whom do you currently live? Include spouse, significant other, children, parents, relatives, and/or friends. Please include ages. (Example: Wendy, sister, aged 7) _____

_____

Please list any **previous complimentary and/or alternative practitioners** you see or have seen (such as chiropractic, acupuncture, massage therapy, naturopath, energy healers, etc.):

Date	Name of therapist or practice	Type of treatment

What do you hope to achieve in your visit with UC Integrative Medicine? _____

_____

If you had the opportunity to heal three of your health concerns, what would they be?

1. _____
2. _____
3. _____

Change Readiness:

Reflecting on those concerns above, **how important** to you is each one on a scale from 1 to 10? (circle number)

1: **Least**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Most**
2: **Least**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Most**
3: **Least**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Most**

Reflecting on those concerns above, **how confident** are you that you can make changes to improve each one?

1: **Low**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Very high**
2: **Low**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Very high**
3: **Low**: 1----------2----------3----------4----------5----------6----------7----------8----------9-------10 **Very high**

Movement history:

How much of your waking day is spent sitting? Very little ☐ About half the day ☐ Most of the day ☐
What kind/s of transportation do you use for most of your work or local travel? On foot/Walking ☐ Bicycle ☐
Family member/Friend drives me ☐ Hired driver (Taxi/Uber) ☐ My private car ☐ Public transportation ☐

Please share your exercise activities with us:

Type	Which Activity?	How many days a week?	# of Minutes
Stretching			
Cardio/Aerobics (w/ heart rate target)			
Strength/ Weight lifting			
Walking/ Hiking			

Sports Activities (golf, tennis, etc.)			
Combo (Yoga, Pilates, Tai Chi, etc.)			

Please share with us any concerns that **limit** your physical activity: _____

Sleep history:

Have you ever had or do you have insomnia (trouble falling asleep or staying asleep)? Yes ☐ No ☐
If yes, please describe: _____

What is your best bedtime? _____What is your best wake-up time? _____Do you need an alarm? Yes ☐ No ☐

How many hours of sleep do you actually get each day during the week? _____ Weekend? _____

Do you use sleeping aids? Yes ☐ No ☐ If yes, please describe: _____

Do you awaken feeling rested? Yes ☐ No ☐ If no, please explain: _____

Emotion inventory:

Have you experienced any major losses in life? Yes ☐ No ☐

If yes, was this (check all that apply): In childhood? ☐ Teens? ☐ Adulthood? ☐ In past five years? ☐

Please explain further if willing: _____

How important is religion (or spirituality or faith) for you and for your family?

☐ Not at all important ☐ Somewhat important ☐ Extremely important

Comments? _____

Who are your resources for emotional support? _____

Please share your "Time Out" practices for managing stress (meditation, yoga, massage, deep breathing, prayer, etc.):

_____

Unfortunately, abuse and violence of all kinds including verbal, emotional, physical and sexual are leading contributors to chronic stress and illness. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it so we may support you and optimize your treatment outcomes. If you would feel safer discussing these issues with us in private, or not at all, please simply mark "discuss in person" or "keep private" and move to the next section.

Did you feel safe growing up? Yes ☐ No ☐

Have you been involved in abusive relationships? Yes ☐ No ☐

Was the abuse of alcohol or other substances present in your childhood home/relationships? Yes ☐ No ☐

Is the abuse of alcohol or other substances present in your current home/relationships? Yes ☐ No ☐

Do you currently feel safe in your home? Yes ☐ No ☐

Do you currently feel safe, respected and valued in your current relationship/s? Yes ☐ No ☐

Have you had any violent or otherwise traumatic life experiences? Yes ☐ No ☐

Have you witnessed any violence or abuse? Yes ☐ No ☐

I prefer to discuss these matters in person: Yes ☐ I prefer not to discuss at all (keep private): Yes ☐

I have seen a mental health counselor or psychologist in the past Yes ☐ No ☐ If yes, when? _____

I am currently seeing a mental health counselor or psychologist Yes ☐ No ☐ If yes, how often?_____

Medical History

Please check "yes" for the health conditions that you have ever had diagnosed by your doctor and provide the approximate date of onset.

Condition	Yes	Onset Date
Gastrointestinal		
Irritable bowel syndrome	☐	_____
Inflammatory bowel disease	☐	_____
Crohn's disease/ulcerative colitis	☐	_____
Gallstones/gallbladder problems	☐	_____
Celiac disease	☐	_____
Gastric or peptic ulcer disease	☐	_____
GERD/heartburn	☐	_____
Hepatitis B, C, and/or liver disease	☐	_____
Food intolerance/sensitivity	☐	_____
Other: _____	☐	_____
Cardiovascular/Blood		
High blood pressure	☐	_____
High blood cholesterol/lipids	☐	_____
Irregular heart beat	☐	_____
Heart attack or angina	☐	_____
Heart failure/CHF	☐	_____
Stroke/TIA	☐	_____
Blood clots	☐	_____
Anemia	☐	_____
Rheumatic fever	☐	_____
Other: _____	☐	_____
Respiratory		
Asthma	☐	_____
Bronchitis	☐	_____
Pneumonia	☐	_____
Emphysema/COPD	☐	_____
Sleep apnea	☐	_____
Sinusitis	☐	_____
Other: _____	☐	_____
Neurological/Brain		
Seizures	☐	_____
Depression/anxiety	☐	_____
Migraine	☐	_____
Parkinson's disease/tremor	☐	_____
Bipolar disorder	☐	_____
ADD/ADHD	☐	_____
MS (Multiple Sclerosis)	☐	_____
Anorexia nervosa	☐	_____
Bulimia	☐	_____
Alcohol or other drug abuse	☐	_____
Dementia	☐	_____
Insomnia	☐	_____
Other: _____	☐	_____

Skin Diseases		
Acne	☐	
_____		
Dermatitis	☐	
_____		
Other: _____	☐	
_____		
Condition	**Yes**	**Onset Date**
Inflammatory		
Chronic fatigue syndrome	☐	_____
Rheumatoid arthritis	☐	_____
Lupus (SLE)	☐	_____
Frequent infections	☐	_____
Mononucleosis	☐	_____
Herpes	☐	_____
Gout	☐	_____
Hives	☐	_____
Psoriasis	☐	_____
Vitiligo	☐	_____
Dental or gum disease	☐	_____
Other: _____	☐	_____
Urinary/Reproductive		
Kidney stones	☐	_____
Urinary tract infection	☐	_____
Interstitial cystitis	☐	_____
Prostate problems	☐	_____
Yeast infections	☐	_____
Other: _____	☐	_____
Endocrine		
Diabetes (Type 1 or 2)	☐	_____
Hypoglycemia	☐	_____
Polycystic ovary syndrome	☐	_____
Thyroid concerns (hi/low)	☐	_____
PMS/endometriosis	☐	_____
Overweight	☐	_____
Other: _____	☐	_____
Chronic Infections		
Hepatitis B	☐	_____
HIV/AIDS	☐	_____
Tuberculosis	☐	_____
Other: _____	☐	_____
Musculoskeletal/Pain		

Fibromyalgia	☐ _____	Breast	☐ _____
Osteoarthritis	☐ _____	Lung	☐ _____
Chronic headache	☐ _____	Colon or rectal	☐ _____
Chronic pain	☐ _____	Pancreatic	☐ _____
Other: _____	☐ _____	Leukemia or lymphoma	☐ _____
		Prostate	☐ _____
Cancer		Other: _____	☐ _____

Please list additional health concerns not mentioned above:

Date of Onset	Concern

Please list previous surgeries, injuries, and/or hospitalizations (if additional space needed, attach a separate page):

Date	Surgery/injury/hospitalization

Please list all **PRESCRIBED** medications you take regularly (If additional space is needed, please attach a separate page):

Medication	Dose	Frequency	Start Date

Are you allergic to any medications? Yes ☐ No ☐ If yes, please list: _____

Have your medications ever caused you any unusual side effects or concerns? Yes ☐ No ☐

If yes, please describe: _____

Please list all **NON-PRESCRIPTION** over-the counter medications (OTC), supplements, herbal and vitamin/mineral products. Indicate the form of supplement if possible (e.g., calcium carbonate vs calcium lactate). If additional space needed, please use a separate piece of paper.

OTC/Supplement and brand	Dose	Frequency	Start Date

How often have you taken **antibiotics** (for infections such as ear, strep, sinus, bladder, respiratory, other conditions such as acne, or as a pre-procedure medication) or oral, injected or cream/lotion **steroids** (e.g., Cortisone, Prednisone, etc. for conditions such as rashes, asthma, joint swelling, breathing concerns)?

Age Period	< 5 Times	≥ 5 Times	For what condition/s?
Infancy/Childhood			
Adolescence/Teen			
Adult			

Personal Habits:

Are you currently smoking **tobacco**? Yes ☐ No ☐ If yes, how many years? _____ Packs per day: _____

Have you smoked tobacco in the past? Yes ☐ No ☐ If yes, how many years? _____Packs per day: _____

How many **alcohol** containing drinks do you consume a week? *(1 drink = 5 ounces of wine, 12 ounces of beer, 1.5 ounces of spirits)*

None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10 ☐

Are you currently using any type of recreational **drug**? Yes ☐ No ☐ If yes, type and frequency: _____

Nutrition History

Height: _____ Current weight: _____ Highest adult weight: _____ Lowest adult weight: _____ Desired weight: ____

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

If yes, please explain: _____

Do you currently follow a special diet or nutritional program? Yes ☐ No ☐ If yes, please check all that apply:

Low fat ☐ Low carbohydrate ☐ High protein ☐ Diabetic ☐ Low sodium ☐ No dairy ☐

No wheat ☐ Vegetarian ☐ Vegan ☐ Paleo ☐ Ketogenic ☐ Elimination ☐

Other_____ If following a particular diet book or author, please share the name: _____

Do you grocery shop? Yes ☐ No ☐ If no, who does the grocery shopping? _____

Do you cook? Yes ☐ No ☐ If no, who does the cooking? _____

Do you read nutrition facts labels on food containers? Yes ☐ No ☐

How many meals do you eat "out" each week? _____ Which meals do you typical eat "out"? _____

Do you have any food **allergies** (such as tree nuts, seafood or celiac disease)? Yes ☐ No ☐

If yes, are these your observations or have you had specific testing? Please explain: _____

_____

Do you have any food **intolerances** (such as lactose or gluten intolerance)? Yes ☐ No ☐

If yes, please explain: _____

Please check all the factors below that apply to your current lifestyle and **eating habits**:

Fast eater	☐	Significant other or family members have special dietary needs or preferences	☐
Erratic eating pattern	☐		
Eat too much	☐	Love to eat	☐
Late night eating	☐	Eat because I have to	☐
Dislike "healthy" food	☐	Have a negative relationship with food	☐
Time constraints	☐	Struggle with eating issues	☐
Eat more than 50% of meals "out"	☐	Emotional eater (eat when sad, lonely, bored)	☐
Travel frequently	☐	Eat too much when under stress	☐
Non-availability of healthy foods	☐	Eat too little when under stress	☐

Do not plan meals or menus	☐	Eat mindlessly (driving, in front of TV, etc.)	☐
Reliance on convenience items	☐	Eat in the middle of the night	☐
Make poor snack choices	☐	Confused about nutrition advice	☐
Family members don't like healthy foods	☐	Frequently skip meals	☐

Additional comments not mentioned above: _____

Do you have problems with: Chewing ☐ Swallowing ☐ Indigestion/ Heartburn ☐ Nausea ☐ Vomiting ☐

Belching/ Burping ☐ Passing a lot of gas ☐ Bloating/ Distended belly ☐ If yes, how soon after eating? _____
How long lasting? _____ Other symptoms? _____

Bowel habits:

Frequency of bowel movements: Once a Day ☐ Several times daily ☐ Once every 2-3 days ☐ > 4 days ☐

Do you have bouts of: Diarrhea (loose and sometimes urgent) ☐ Constipation (hard, difficult to pass) ☐

If so, please explain and indicate treatments tried (if any): _____

Have you had **tests**: Upper scope (looking into stomach) ☐ If checked, when?_____ Findings: _____

Lower scope (colonoscopy) ☐ If checked, last was when? _____ Findings: _____

Food Journaling:

Please record, on the following food diary tables, what you eat and drink for typical **3 days**. If your eating patterns are different on the weekend, please include 1 weekend day as well. Include all beverages and cream(er), sweeteners, and condiments added to foods and beverages. Please feel free to attach a separate sheet if you need more room to list your food intake.

Day 1

Time woke up:		**Bedtime:**
Time	Food/Beverage Items	Amount *(e.g. cups, oz.)*

Day 2

Time woke up:		**Bedtime:**
Time	Food/Beverage Items	Amount *(e.g. cups, oz.)*

Day 3

Time woke up:		**Bedtime:**
Time	Food/Beverage Items	Amount *(e.g. cups, oz.)*
