Dear Valued Patient,

Thank you for your interest in UC Health’s Integrative and Functional Medicine clinical services. We 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 behavior, nutrition, movement, sleep, and your environment to reduce stress and promote overall wellness.

Dr. Barbara Walker’s practice focuses on health and performance psychology partners with individuals to achieve their optimal energy, health, and performance using a skill-based educational approach to mind-body medicine using modalities such as biofeedback, relaxation training, mindfulness, solution oriented cognitive behavioral strategies with the goal of self-regulation. Areas such as sleep, movement, exercise, eating behavior are addressed.

To better serve you and all of our patients, UC Health Integrative Medicine requires all new patients to complete and return the New Patient Intake Questionnaire along with a copy (front/back) of their insurance card prior to being scheduled for their first appointment. This improves our providers’ ability to better serve your needs, while simultaneously increasing access allowing more new patients into the program. **If you need assistance filling out this form, please contact the office at 513-475-WLNS (9567).**

Attached is our **New Patient Intake Questionnaire**, please complete and send back to us. **We strongly encourage you keep a copy of this paperwork for your records.**

You can send your paperwork and a copy of your insurance card (front/back) by:

1. Emailing: Marchelle.Copeland@UCHealth.com
2. Fax: (513) 475-9231 Attn: Marchelle Copeland
3. Mailing to: **(Please allow 21 days for USPS mail deliveries)**
   UC Health West Chester MOB South
   Attn: Integrative Medicine
   7675 Wellness Way, Suite 420
   West Chester, OH 45069

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

-**Your Integrative Medicine Care Team**

If you have any questions, feel free to contact us at 475- WLNS (9567) or email: Marchelle.Copeland@UCHealth.com
UC Health Integrative Medicine Appointment Policy

Effective April 2017

We respect your time. That is why, we are implementing an Appointment Policy to address no shows, cancellations and late arrivals. We hope this policy will help our continued focus on better serving our patients and providing excellent customer service.

1. Arrival Time:
   a. New Patients
      i. New Patients are expected to arrive 15 minutes before scheduled appointment time. This allows time for check in and optimizes time with your provider. Your new patient questionnaire should be completed and returned by your scheduled appointment time.
   b. Established Patients
      i. All Established Patients are expected to arrive 10-15 minutes before scheduled appointment time.

   **Please be mindful of your appointment time. Arriving at the exact time of your scheduled appointment causes delays not only for you, but also for patients being seen after you.**

2. Arriving Late to Appointments:
   a. Patients arriving 15 minutes or later to their scheduled appointment may be asked to reschedule their appointment.

3. Cancellations & Rescheduling of Appointments:
   a. We require 24-hour cancellation or rescheduling notice for all office appointments.
   b. Cancellations less than 24 hours in advance will be considered a “no show”.

4. Dismissal from Practice:
   a. Should a patient late cancel or “no show” their scheduled office appointment 3 times with any of our UC Health Integrative Medicine providers, it may result in dismissal from the practice.

Patient Name: __________________________
Date of Birth: __________________________
Patient Signature: ________________________
Date: __________________________________

**This policy is subject to change at any time.**
Health and Performance Psychology New Patient Questionnaire

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.

First Name: __________________________  Middle Initial: _______  Last Name: ________________________________

Referred by: ____________________________________________

Date of Birth: _______________  Age: _______  Gender: __________________  Height: _______  Weight: _______

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

Emergency Contact Name and Phone: ________________________________________________________________

Email address: ____________________________________________________________

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

Current Employment: ____________________________________________________________________________

Occupation: ____________________________________________________________________________________

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? _______________________________________________________________________

Primary Reason for Consultation: (Please check any and all that apply + add any additional details)

☐ Sport Psychology
☐ Performance Issues
☐ Stress Management/Relaxation
☐ Management of Depression/Fatigue
☐ Management of Anxiety Symptoms
☐ Career Management

☐ Biofeedback
☐ Discuss coping strategies regarding recent diagnosis
☐ Seeking behavioral strategies to improve _____________

☐ Mindfulness/Meditation
☐ Family Issues
☐ Conflict Resolution

☐ Other: _________________________________________________________________________________________
What are the top three objectives that you would like to achieve as a result from our sessions?

1. _______________________________________________________________________________________
2. _______________________________________________________________________________________
3. _______________________________________________________________________________________

Managing Stress

What are your Current Stressors, including any perceived barriers that are inhibiting you from reaching your goals?
________________________________________________________________________________________
________________________________________________________________________________________

How would you rate your current level of stress?
Low – 0 1 2 3 4 5 6 7 8 9 10 - High

How would you describe your current level of emotional and/or spiritual support?
Very Poor – 0 1 2 3 4 5 6 7 8 9 10 – Very Good

How would you describe your current level of anxiety?
No problem - 0 1 2 3 4 5 6 7 8 9 10 - Major problem

During the last 30 days, how often have you felt Sad or Down/depressed?
Never - 0 1 2 3 4 5 6 7 8 9 10 - Consistently

To what degree do you feel hopeful about your health/resolving your issues?
Little/no hope - 0 1 2 3 4 5 6 7 8 9 10 - Very Hopeful!

How do you feel you are currently coping with life in general?
☐ Seldom stressed ☐ Sometimes stressed ☐ Often stressed ☐ Heavily stressed ☐ Excessively stressed

In what ways do you regularly manage stress:
☐ Acupuncture ☐ Deep Breathing ☐ Drinking Alcohol ☐ Eating ☐ Exercise
☐ Journaling ☐ Massage ☐ Meditation ☐ Praying ☐ Talking to Family/Friends
☐ Sleep ☐ Sex ☐ Yoga
☐ Other: ___________________________________________

Where do you feel that you typically carry stress in your body? (check all that apply):
☐ Head (difficulty concentrating/too many thoughts) ☐ Tension Headaches
☐ Migraines ☐ Shoulder/Traps ☐ Back
☐ Overall muscle tightness ☐ Gastro-Intestinal Symptoms

What do you do for fun/relaxation? __________________________________________________________

What brings you joy? ________________________________________________________________

What seems to leave you feeling depleted/low energy? ______________________________________

Revised 09/24/18  UC Health Integrative Medicine
What is your biggest obstacle or barrier to you feeling your best? ____________________________________________

If you felt your best, what would you do differently and how would this change your life?________________________

Past history:
Have you ever seen a counselor or therapist? □ Yes □ No □ Currently
Reason: ______________________________

Do you have any history of:
- Verbal, physical, sexual or emotional abuse? □ Yes □ No □ Currently
- Alcohol Dependency □ Yes □ No □ Currently
- Anxiety □ Yes □ No □ Currently
- Depression □ Yes □ No □ Currently
- Suicidal Ideation or Attempts □ Yes □ No □ Currently
- Substance Abuse □ Yes □ No □ Currently
- Eating Disorder □ Yes □ No □ Currently
- How supportive are your family and friends? □ Very □ Somewhat □ Not very supportive

Personal Habits:

Sleep Routine:
On average, how many hours of sleep do you usually get per night? __________

How many times do you typically wake up through the night? __________

What do you usually do when you awaken during the night?___________________________________________________

Do you read before falling asleep? □ Yes □ No If yes, do you read a book or e-reader? __________

Do you work on a computer/laptop/smartphone before falling asleep or during the night? □ Yes □ No

Please describe any problem(s)/concerns you feel you have with your sleep. Include when and how this started affecting you or your family members, what treatment you have received for this in the past.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________
Eating Habits:

Please describe the quantity and frequency of your use of the following DAILY:

- **Vegetable servings:**
  - 0
  - 1-3
  - 4-6
  - 7+

- **Fruit servings:**
  - 0
  - 1-3
  - 4-6
  - 7+

- **Cups of Water:**
  - 0
  - 1-3
  - 4-6
  - 7-9
  - 10+

- **Homemade meals:**
  - 0
  - 1
  - 2
  - 3

- **Fast food meals:**
  - 0
  - 1
  - 2
  - 3

- **How many snacks:**
  - 0
  - 1
  - 2
  - 3

- **Sugary Beverages:**
  - 0
  - 1
  - 2
  - 3+

- **Diet Beverages:**
  - 0
  - 1
  - 2
  - 3+

- **Alcohol:**
  - 0
  - 1
  - 2
  - 3+

- **Fried Foods:**
  - 0
  - 1
  - 2
  - 3+

Movement/Exercise Routine:

How much of your waking day is spent sitting?

- [ ] Very little
- [ ] About half the day
- [ ] Most of the day

What types of movement, exercise, and/or sports are you currently engaged in and how often?

________________________________________________________________________________________

________________________________________________________________________________________

What **medical conditions or injuries** have you had in the past and may be experiencing currently?

________________________________________________________________________________________

________________________________________________________________________________________

Please list all medications (**NON-PRESCRIPTION** and **Prescription**), 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.

________________________________________________________________________________________

________________________________________________________________________________________

Please indicate your **current readiness** to take action regarding your health goals:

- Not ready to change 0 1 2 3 4 5 6 7 8 9 10 Already changing