UC Health Integrative Medicine

UC Health Physician's Office Midtown
3590 Lucille Drive, Suite 2700
Cincinnati, OH 45213

UC Health Physician's Office South
7675 Wellness Way, 4th Floor
West Chester, OH 45069

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

UC Health Hoxworth Center
3130 Highland Ave,
Cincinnati, OH 45219

P (513) 475-9567
F (513) 475-9231

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 behavior, nutrition, movement, sleep, and your environment to reduce stress and promote overall wellness.

To better serve you and all of our patients, UC Health Integrative Medicine kindly asks that you complete and bring with you the attached **New Patient Acupuncture Intake Questionnaire** along with your photo ID and insurance card to your first appointment.
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!

If you have any questions, feel free to contact us at 475- WLNS (9567)

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. ***

UC Health Integrative Medicine

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Barrett Center
234 Goodman Street 2nd Fl
Cincinnati OH 45219

West Chester
7675 Wellness Way Suite 400
West Chester OH 45069

Phone: (513) 475-WLNS (9567) **Fax:** (513) 475-9231 **Website:** UCHealth.com/Integrative

New Patient Acupuncture Intake Questionnaire

Name		Age:	Today's date: / /
Primary Complaint			**Severity**: /10
Secondary Complaint/s			**Severity**: /10
Current Diagnoses (all)			

Please Fill Out the Following Information and Check the Appropriate Boxes

What stress factors do you experience? (home/work/school etc): _____

_____

_____

Exercise/Movement: _____ X's per week for about _____ minutes

☐ Run ☐ Walk ☐ Bike ☐ Swim ☐ Weights ☐ Other: _____

Mind-Body: _____ X's per week for about _____ minutes

☐ Yoga ☐ Tai Chi ☐ Qigong ☐ Meditation ☐ Other: _____

Hobbies: _____

Spiritual Practice/s: _____ ☐ Daily ☐ Weekly ☐ Other: _____

What helps you: Relax? _____

What helps you: Feel Safe? _____

What makes you happy? _____

Are you unable to do things you enjoy? What are they? _____

_____

_____

When were you healthiest and most happy? What were you doing at that time? _____

_____

_____

Consistently experience:

☐ Anger ☐ Anxiety ☐ Sadness ☐ Worry ☐ Sadness ☐ Fear ☐ Depression
☐ Diarrhea ☐ Constipation ☐ Acid reflux ☐ Nausea ☐ Belching ☐ Vomiting ☐ Abdominal pain

Interfering with:

☐ Work ☐ Sleep ☐ Relationships ☐ Digestion ☐ Other: _____

Sleep:

☐ Good ☐ Poor ☐ Restless ☐ Active dreams ☐ Difficult to fall or stay asleep

Regularly use on the skin:

☐ Lotion ☐ Oil ☐ Essential oil ☐ Cream ☐ Extract ☐ Plaster ☐ Medication
☐ Perfume ☐ Cologne ☐ Antiperspirant/deodorant ☐ Other: _____

Please specify: _____

Food/product sensitivities: _____

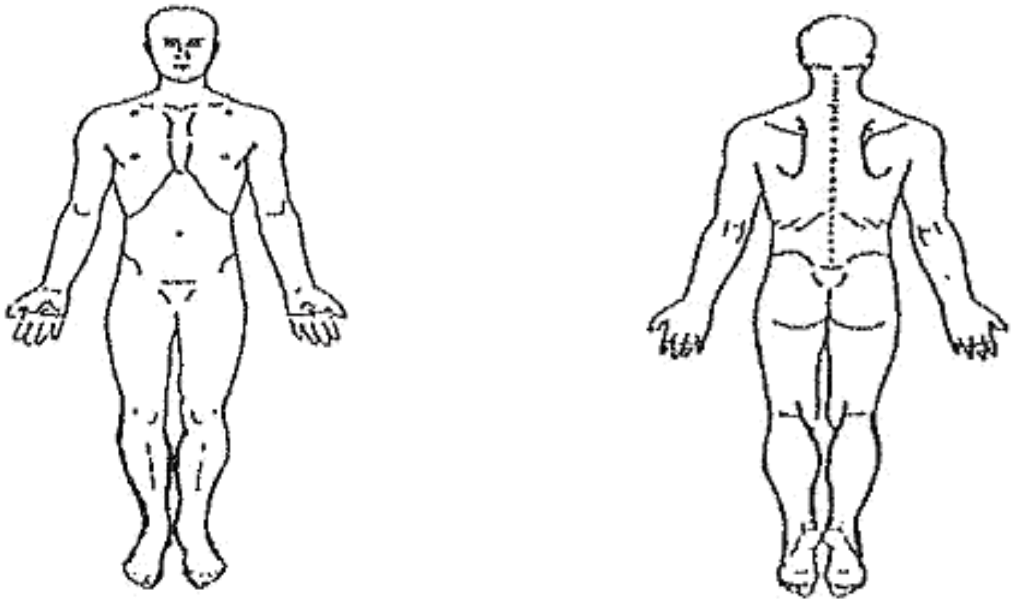
_____

_____

How would you rate your quality of life? ____/10_

Please make sure to complete a three (3) day food diary. This should include all foods, liquids & products you ingest as well as a list of your current medications and supplements.

Please indicate problem areas where applicable



Please Indicate All Symptoms You Are Experiencing or That Frequently Occur

General

- ☐ Poor appetite
- ☐ Insomnia/disturbed sleep
- ☐ Weakness
- ☐ Strong or No thirst
- ☐ Weight gain/loss
- ☐ Change in appetite
- ☐ Easy or difficult to sweat
- ☐ Tremors
- ☐ Cancer
- ☐ Night sweats
- ☐ Fever/chills
- ☐ Cold hands/feet
- ☐ Hot hands/feet
- ☐ Sudden fatigue

Other: _____

Head/Eyes/Ears/Nose/Throat

- ☐ Dizziness
- ☐ Concussion
- ☐ Migraine
- ☐ Headache
- ☐ Eye pain/twitching
- ☐ Night blindness
- ☐ Tired vision
- ☐ Cataracts
- ☐ Blurred vision
- ☐ Earache/infection
- ☐ Tinnitus
- ☐ Difficulty hearing
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips/tongue
- ☐ Tightness in throat

Other: _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Belching
- ☐ Abdominal pain
- ☐ Chronic laxatives
- ☐ Heart burn
- ☐ Acid reflux
- ☐ Bad breath
- ☐ Gas/bloating
- ☐ Blood in stool
- ☐ Rectal pain
- ☐ Hemorrhoids

Other: _____

Cardiovascular

- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat/pulse
- ☐ High blood pressure
- ☐ Swelling
- ☐ Blood clots
- ☐ Heart palpitations
- ☐ Fainting

Other: _____

Respiratory

- ☐ Cough
- ☐ Coughing up blood
- ☐ Excessive phlegm
- ☐ Asthma
- ☐ Pain during inhale
- ☐ Allergies
- ☐ Chronic infections

Other: _____

Reproductive and Gynecologic

- ☐ Premenstrual changes
- ☐ Premature birth
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Infertility
- ☐ Miscarriage
- ☐ Hysterectomy
- ☐ Cysts or fibroids
- ☐ Irregular cycle
- ☐ Endometriosis

Other: _____

Musculoskeletal/Pain

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Foot/ankle pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Arthritis
- ☐ Traumatic injury
- ☐ Muscle weakness
- ☐ Sports injury

Other: _____

Skin and Hair

- ☐ Rash
- ☐ Ulceration
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Change in texture

Other: _____

Genitourinary

- ☐ Pain with urination
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Sores on genitals
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Male impotence
- ☐ Frequent night urination

Other: _____

Neuro/psychological

- ☐ Concussion
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Seizures
- ☐ Numbness
- ☐ Loss of function
- ☐ Abnormal emotions
- ☐ High Stress
- ☐ Depression
- ☐ Anxiety

Other: _____