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. **
# New Patient Acupuncture Intake Questionnaire

Please Fill Out the Following Information and Check the Appropriate Boxes

<table>
<thead>
<tr>
<th>Name</th>
<th>Age:</th>
<th>Today’s date: / /</th>
</tr>
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**Primary Complaint**

Severity: /10

**Secondary Complaint/s**

Severity: /10

**Current Diagnoses (all)**

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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? ________________________________________

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UC Health Integrative Medicine

Midtown
3590 Lucille Drive Suite 2700
Cincinnati OH 45213

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
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
Other: ____________________________

**Head/Eyes/Ears/Nose/Throat**
- □ Dizziness
- □ Concussion
- □ Migraine
- □ Headache
- □ Eye pain/twitching
- □ Night blindness
- □ Tired vision
- □ Cataracts
- □ Blurred vision
Other: ____________________________

**Gastrointestinal**
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Belching
- □ Abdominal pain
- □ Chronic laxatives
Other: ____________________________

**Cardiovascular**
- □ Low blood pressure
- □ Chest pain
- □ Irregular heartbeat/pulse
- □ High blood pressure
Other: ____________________________

**Respiratory**
- □ Cough
- □ Coughing up blood
- □ Excessive phlegm
- □ Asthma
Other: ____________________________

**Reproductive and Gynecologic**
- □ Premenstrual changes
- □ Premature birth
- □ Menstrual clots
- □ Painful menses
- □ Heavy menstrual flow
- □ Light menstrual flow
Other: ____________________________

**Musculoskeletal/Pain**
- □ Neck pain
- □ Shoulder pain
- □ Back pain
- □ Foot/ankle pain
- □ Knee pain
Other: ____________________________

**Skin and Hair**
- □ Rash
- □ Ulceration
- □ Hives
- □ Itching
- □ Eczema
Other: ____________________________

**Genitourinary**
- □ Pain with urination
- □ Kidney stones
- □ Frequent urination
- □ Urgency to urinate
- □ Unable to hold urine
Other: ____________________________

**Neuro/psychological**
- □ Concussion
- □ Loss of balance
- □ Poor memory
- □ Seizures
- □ Numbness
Other: ____________________________

Please fill in all symptoms that apply or occur frequently.