UC Health Integrative Medicine

UC Health Garner Neuroscience Institute
3113 Bellevue Ave.
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 choosing UC Health Integrative Medicine for **Acupuncture Therapy**.

To better serve you and all patients, we kindly ask that you arrive 15 minutes before your scheduled appointment time to allow enough time for registration and to maximize your treatment time. Please bring with you completed **New Patient Intake Questionnaire,** photo ID and insurance card.

We encourage all patients to wearing loose-fitting clothing and/or to bring a change of clothes that are loose-fitting to be able to access treatment sites (shorts and short sleeves are preferred.) For your convenience, we can also provide a gown if preferred.

We also recommend eating a light snack before your visit and to please plan on no heavy activity/exercise for at least a 3 hours after treatment.

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

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 need assistance filling out this form, please contact the office at 513-475-WLNS (9567).

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UC Health Integrative Medicine Appointment Policy- 2019

We respect your time. That is why, we have implemented 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 15-20 minutes before scheduled appointment time. This allows time for check in and optimizes time with your provider.
   - **b. Established Patients**
     - i. All Established Patients are expected to arrive 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 within a rolling 12 month period with any of our UC Health Integrative Medicine providers, it may result in dismissal from the practice.

Patient Name: _____

Patient Signature: _____

Date: _____

***This policy is subject to change at any time. ***

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UC Gardner Neuroscience Institute
3113 Bellevue Ave; 4th Floor
Cincinnati OH 45219

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

West Chester Women's Center
7675 Wellness Way; Suite 400
West Chester OH 45069

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

Acupuncture Therapy New Patient Questionnaire

Today's Date: _____Name: _____ D.O.B.: _____Age: _____

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

Email: _____ Occupation: _____Employer: _____

Home phone: _____ Work phone: _____ Cell: _____

At what number do you prefer to be contacted? ☐ Home ☐ Cell ☐ Work

Are you new to UC Health? ☐ Yes ☐ No

How did you learn about UC Health Integrative Medicine?

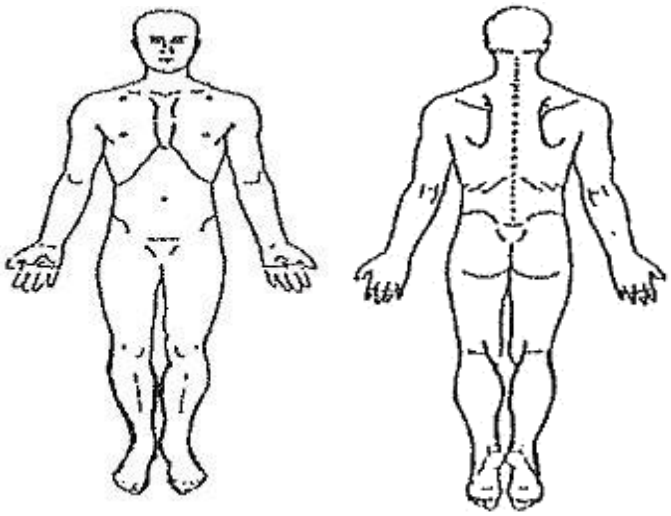
Referred by: _____ ☐Physician Referral ☐Friend/Family ☐Internet ☐Social Media ☐Flyer/Brochure ☐Insurance Company ☐Website ☐Other:_____

PRIMARY HEALTH CONCERN:

Please list the primary health concern(s) you hope to address during your visit below and rate your level of pain/discomfort.

Primary Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Secondary Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Other Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Other Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
Other Complaint	
Severity 0-10	***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***

Please indicate problem areas where applicable



How do you rate your overall health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Are you unable to perform daily tasks? ☐ Yes ☐ No

If yes, what are they? (please list)

_____

_____

Are you unable to do things you enjoy? ☐ Yes ☐ No

If yes, what are they? (please list)

_____

_____

Do you use any of the following or regularly apply to your skin:

☐ Lotion ☐ Oil ☐ Essential oil ☐ Cream ☐ Extract ☐ Plaster ☐ Medication

☐ Perfume ☐ Cologne ☐ Antiperspirant/deodorant ☐ Other: _____

Please list ALL product sensitivities and reactions:

Name of Product:	**Reaction?**
_____	_____
_____	_____
_____	_____
_____	_____

INTEGRATIVE THERAPIES

Please check any **integrative therapies** that you have tried, if they have helped or not, and if you are currently using them:

Therapy:	Tried?	Helpful?	Currently Use?	How often?	With whom/where?
Physical therapy	☐	☐Yes ☐No	☐	_____	_____
Talk therapy/Counseling	☐	☐Yes ☐No	☐	_____	_____
Massage therapy	☐	☐Yes ☐No	☐	_____	_____
Yoga	☐	☐Yes ☐No	☐	_____	_____
Chiropractic	☐	☐Yes ☐No	☐	_____	_____
Acupuncture	☐	☐Yes ☐No	☐	_____	_____
Meditation	☐	☐Yes ☐No	☐	_____	_____
Tai Chi/Qigong	☐	☐Yes ☐No	☐	_____	_____

Other Integrative Healthcare Providers you are working with: _____

SLEEP HEALTH

1. How would you rate your sleep quality? ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
2. On average, how many hours of sleep do you usually get per night? ❑ less than 4 ❑ 4-6 ❑ 6-8 ❑ more than 8
3. How many times do you typically wake up through the night? ❑ 0 ❑ 1-2 ❑ 2-3 ❑ more than 3
4. What do you usually do when you awaken during the night? _____
5. Do you read before falling asleep? ❑ Yes ❑ No If yes, do you read a book or e-reader? ❑ Yes ❑ No
6. Do you watch TV before falling asleep? ❑ Yes ❑ No Is the TV in the bedroom? ❑ Yes ❑ No
7. Do you work on a computer/laptop/smartphone before falling asleep or during the night? ❑ Yes ❑ No
8. If you have taken medications for insomnia in the past? ❑ Yes ❑ No If yes,what have you tried?_____
9. Do you currently take any sleep aides? ❑ Yes ❑ No If yes, what are you taking_____
10. Do you awake feeling rested? ❑ Yes ❑ No
11. How do you usually spend your first 30 minutes upon awakening? (check all that apply)

    ❑ Lay awake in bed ❑Meditate/Pray ❑ Review to do list for the day

    ❑ Bathroom ❑ Coffee ❑ Water ❑ Exercise ❑ Watching TV/News

    Other: _____

If ongoing problems with sleep, please describe any 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. (*Please answer with as much detail as possible*).

_____

_____

EXERCISE HISTORY

1. How would you rate your overall energy level? ***Low*** 0 1 2 3 4 5 6 7 8 9 10 ***High***
2. How often do you exercise? ☐ No exercise ☐ Once a week ☐ Twice a week ☐ Three times a week or more
3. Work related: ☐ Mainly sitting ☐ Up and down ☐ Mainly active
4. Are you able to perform exercises such as walking 3 blocks, swimming or using exercise bike? ☐ yes ☐ no

Physical Limitations Preventing Exercise: *Please circle the appropriate response:*

Hip pain	☐ yes	☐ no	Back pain	☐ yes	☐ no
Knee pain	☐ yes	☐ no	Fatigue	☐ yes	☐ no
Ankle pain	☐ yes	☐ no	Diaphoresis (sweating)	☐ yes	☐ no
Foot pain	☐ yes	☐ no	Shortness of breath	☐ yes	☐ no

EMOTIONAL AND BEHAVIORAL HEALTH

1. What do you do for fun/relaxation? _____

2. What brings you joy? _____

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

_____

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

_____

_____

5. What seems to leave you feeling depleted/ low energy? _____

_____

_____

6. What is your *biggest obstacle* or *barrier* to you feeling your best? _____

_____

7. How would you rate your current level of stress? Please circle below:
   Low 0 1 2 3 4 5 6 7 8 9 10 ***High***

8. 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***

9. How would you describe your *current level* of anxiety?

   No problem 0 1 2 3 4 5 6 7 8 9 10 ***Major problem***

10. 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***

11. To what degree do you feel hopeful about your health/resolving your issues?

    Little or no hope 0 1 2 3 4 5 6 7 8 9 10 ***Very Hopeful!***

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

_____

13. How important is religion (or spirituality or faith) for you and for your family?
    ☐ Not at all important ☐ Somewhat important ☐ Extremely important

    More details? _____

14. In what ways do you regularly manage stress:

☐ Acupuncture ☐ Deep Breathing ☐ Drinking Alcohol ☐ Eating ☐ Exercise ☐ Journaling

☐ Massage ☐ Meditation ☐ Praying ☐Talking to Family/Friends ☐ Sleep ☐ Baths ☐ Yoga

Other: _____

DIGESTION/NUTRITION

1. Do you have problems with any of the following?
   ☐Indigestion/heartburn ☐ Nausea and/or vomiting ☐ Belching/burping ☐ Bloating/distended belly
   ☐ Diarrhea ☐ Constipation ☐ Gastroesophageal Reflux Disease (GERD) Other? _____
2. Describe your bowel frequency: ☐ Once daily ☐ Several daily ☐ Once every 2-3 days ☐ Once every 4+ days
3. Have you had any intestinal surgery? ☐ Gall bladder ☐ Stomach ☐ Appendix ☐ Part of intestines removed
   ☐ Bariatric/lap band Any scopes/ if so, when? ☐ Upper Intestinal Scope ☐ Lower Intestinal Scope
4. Have you made changes in your eating habits because of your health? ☐ No ☐ Yes
   If so, how? _____
5. Do you follow a certain dietary lifestyle? ☐ Vegan ☐ Vegetarian ☐ Omnivore ☐ Gluten Free
6. How often do you track calories or food intake? ☐ Daily ☐ 2 – 3 times a week ☐ 1 time a week or less
7. How many meals do you eat daily? _____
8. Do you snack between meals? ☐ Yes ☐ No
9. Are there foods you crave? ☐ Yes ☐ No Please list: _____
10. Are there foods you avoid? ☐ Yes ☐ No Please list: _____
11. Are you able to make your own food choices and control your food environment? ☐ Yes ☐ No ☐ Variable
12. Do you have problems with any foods? ☐ None that I know of ☐ Yes
    ☐ Dairy ☐ Eggs ☐ Fruits ☐ Nuts ☐ Meats ☐ Soy ☐ Sugar ☐ Wheat Other? _____
13. Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No Please describe: _____
14. Do you have concerns about your relationship with food? ☐ Yes ☐ No Please describe: _____
15. Do you ever: (Check all that apply) ☐ feel rushed at meals ☐ eat excessively if bored or emotional ☐ sneak or hide food ☐ Eat at my desk ☐ Eat in front of the TV ☐ Feel sick or stuffed after eating ☐ Frequently skip meals ☐ Feel satisfied after eating
16. Do you use artificial sweeteners? ☐ No ☐ Yes, Which one? _____

REVIEW OF SYMPTOMS

Constitution
- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Malaise/Fatigue
- ❑ Diaphoresis
- ❑ Weakness

Skin
- ❑ Rash
- ❑ Itching

HENT
- ❑ Hearing Loss
- ❑ Tinnitus
- ❑ Ear Pain
- ❑ Ear Discharge
- ❑ Nosebleeds
- ❑ Congestion
- ❑ Sinus Pain
- ❑ Stridor
- ❑ Sore Throat

Eyes
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Photophobia
- ❑ Eye Pain
- ❑ Eye Discharge
- ❑ Eye Redness

Cardiovascular
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Orthopnea
- ❑ Claudication
- ❑ Leg Swelling
- ❑ PND

Respiratory
- ❑ Cough
- ❑ Hemoptysis
- ❑ Sputum Production
- ❑ Shortness of Breath
- ❑ Wheezing

GI
- ❑ Heartburn
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in Stool
- ❑ Melena

GU
- ❑ Dysuria
- ❑ Urgency
- ❑ Frequency
- ❑ Hematuria
- ❑ Flank Pain

Musculo
- ❑ Myalgias
- ❑ Neck Pain
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Falls

Endo/Heme/Aller
- ❑ Easy Bruise/Bleed
- ❑ Env Allergies
- ❑ Polydipsia

Neurological
- ❑ Dizziness
- ❑ Headaches
- ❑ Tingling
- ❑ Tremor
- ❑ Sensory Change
- ❑ Speech Change
- ❑ Focal Weakness
- ❑ Seizures
- ❑ LOC

Psychiatric
- ❑ Depression
- ❑ Suicidal Ideas
- ❑ Substance Abuse
- ❑ Hallucinations
- ❑ Nervous/Anxious
- ❑ Insomnia
- ❑ Memory Loss

Anything else you would like us to know about you?

_____

_____

_____