



PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY.
ALL QUESTIONS ARE OPTIONAL; SKIP QUESTIONS THAT DO NOT APPLY TO YOU.
THANK YOU.

Name: _____

D.O.B.: _____ Sex: _____

Primary Care Provider: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Work: _____ Cell: _____

Please provide email so that we may update you on current classes, workshops, and also provide you with a quarterly issue of our newsletter LifeSpan: _____

Please describe your goals and expectations regarding your appointment at the Integrative Medicine Clinic:



If you are experiencing pain now or having on-going pain please fill out the following section.

Pain:

Location: _____

Quality: _____

Radiation: _____

What makes it better? _____

What makes it worse? _____

How long have you had it? _____

Mark an X on the line where your pain is currently:

*No
pain*

*Worst
pain ever*

0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities:

Please describe any accidents you have had (include dates, injuries):



Medical conditions/illnesses/Past medical history:

Menstrual history (Women) including last menstrual period:

Psychiatric Hospitalizations:

Surgeries (provide dates of procedures):

Current medications (not herbs or supplements):



Please list any natural health products (herbs, supplements, vitamins, special foods) you are currently using:

Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____
Product: _____	Brand: _____	Dose: _____	How often: _____

Allergy/intolerances to medication or substances:

Current/recent medical and other health care providers (please give names; include physical therapy, psychology, etc.):

Please list which Complementary and Alternative therapies or practitioners (give names) you have tried:



Please list year of most recent:

Colonoscopy _____
 Stool test _____
 Flu shot _____
 Mammogram _____
 PAP smear _____

How would you describe your health (circle one): Poor Average Good

Family history of health problems or conditions (parents, spouse, siblings, children, grandparents if applicable):

Social History:

How many sexual partners have you had in the last year? _____

Describe the current state of your finances: _____

Education level: _____

Occupation: _____

Please describe your religion/spirituality: _____

Hobbies: _____

Housemates/living situation: _____

If you presently follow any regular exercise program, please list what it is, when you started, and how many times per week you do the exercise: _____



Please list the types of volunteer work and hobbies that you do (both current and previous).

Volunteer work or hobbies

Year

List the things that cause you the most stress in your life now (e.g. relationships, family, health, money, job, etc.) and number them in order of significance

How would you rate your stress level in the past month? Place an X or circle the appropriate spot on the line below:

*No
Stress*

*Completely
Stressed Out*

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month? Place an X or circle the appropriate spot on the line below:

Sad

Happy

0 1 2 3 4 5 6 7 8 9 10

Would you consider yourself to be more of an optimist or a pessimist? Place an X or circle the appropriate spot on the line below:

Pessimist

Optimist



0 1 2 3 4 5 6 7 8 9 10

What do you do for relaxation/coping? _____

Mark an X on the line where your energy level is currently:

*No
energy*

*Highest
energy*

0 1 2 3 4 5 6 7 8 9 10

Mark an X on each line for your energy level at various times of the day:

Morning

Low Energy

High Energy

0 1 2 3 4 5 6 7 8 9 10

Afternoon

Low Energy

High Energy

0 1 2 3 4 5 6 7 8 9 10

Evening

Low Energy

High Energy

0 1 2 3 4 5 6 7 8 9 10

Please describe how fatigue or low energy affects your daily activities:



Describe your sleep (in general):

Please describe how sleep deprivation affects your daily activities:

Diet and Nutrition History:

Do you use coffee? _____ If yes, how much per day? _____

Do you use soda? _____ If yes, how much per day? _____

Do you now or have ever used tobacco? _____ If yes, how much per week? _____

Do you now or have ever used alcohol? _____ If yes, how much per week? _____

Do you now or have ever used marijuana? _____ If yes, how much per week? _____

Do you now or have ever used other drugs (non-prescribed drugs)? _____ If yes, which ones and how much per week?

Recall of dietary intake

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.

Breakfast: _____

Lunch: _____



Dinner: _____

Snacks: _____

Is this a typical day? If not, why not? Please describe:

Are there any types or groups of foods you crave or eat a lot?

Are there any types or groups of foods you dislike or rarely eat?

What do you drink on a typical day?

What type of oil do you cook with? _____

What type of spreads do you add to your foods? _____

How many cups (8 oz) of water do you drink on a typical day? _____

How many servings of fruit do you eat on a typical day?

(1 serving = 1 small piece, or ½ cup juice, or ½ cup canned or chopped, or ¼ cup dried)

How many servings of vegetables do you eat on a typical day?

(1 serving = 1 small piece, or 1 cup fresh leafy greens, or ½ cup raw or cooked, or ¼ cup dried)



Please describe your relationship to food:

Highest weight ever: _____ **Desired weight:** _____

Please describe your mood:

Please describe your childhood:

How would you rate your own health as a child? Good Fair Poor

Please list any major traumas (emotional, verbal, physical, and sexual) you have experienced:



Current symptoms (circle if problematic, explain if necessary):

- Allergy _____
- Arthritis (*where?*) _____
- Asthma _____
- Bitter taste in mouth _____
- Blurry vision _____
- Breathing problems _____
- Brittle nails _____
- Bruising _____
- Bursitis (*where?*) _____
- Cancer/tumor _____
- Chest pain/tightness _____
- Cough _____
- Diabetes _____
- Difficulty concentrating _____
- Digestive problems (*type?*) _____
- Ear ringing _____
- Easily angered _____
- Emphysema _____
- Fatigue _____
- Frequent colds/flu _____
- Hearing problems _____
- Heart condition (*type?*) _____
- Hemorrhoids _____
- High blood pressure _____
- Hot flashes _____
- Infections (*where?*) _____
- Inflammation (*where?*) _____
- Irregular heartbeat _____
- Low blood pressure _____
- Nightmares _____
- Night sweats _____
- Numbness/tingling (*where?*) _____
- Menstrual or Gynecological symptoms _____
- Poor appetite _____
- Poor memory _____
- Rapid heartbeat _____
- Red/dry eyes _____
- Sciatica _____
- Seizures/convulsions _____
- Shortness of breath _____
- Skin condition/rash (*where?*) _____
- Stroke _____
- Trouble sleeping _____
- Urinary problems _____



Varicose veins _____
Weak immune system (*describe*) _____

Is there any other information that you would like to share with us?

Thank you for taking the time to complete this extensive form. This information will be very helpful in your evaluation and assessment.

We look forward to your visit and working with you to meet your goals.

Please visit our website for more information about our activities:

<http://hsc.unm.edu/som/cfl/>