Patel Wellness & Spa• Center for Integrative Medicine

An Integrative Consultation requires the understanding of clients as a whole: ***Mind, body and spirit****. Please take the time to fill out this intake form as completely as possible. This form will help to stimulate areas that may need special attention during your visit. I have reviewed the consent and understand that this consultation is to optimize my health. Any primary care needs will be met by my regular doctor.*

First Name:_____ _____ Last Name:_____

Address:_____

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____ Age: _____

Work Phone: (_____) _____-_____ Ht. _____ô____ ñ Wt. _____ ____ ____

Cell Phone: (_____) _____-_____ Email: _____

May we have your permission to email information about topics that may interest you? (circle)
YES NO

How did you hear about this office? _____

Emergency Contact (name and phone #): _____

Primary Care Provider:_____

Todayôs Date: _____

Describe your primary health and wellness goals:

1._____

2._____

3._____

Note: Please provide all reports, letters, lab work, etc. that can help to evaluate and treat the problems listed below.

Describe your most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your second most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your third most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Review of Symptoms:

Constitutional

- ☐ Good general health
- ☐ Recent weight change
- ☐ Headaches
- ☐ Fever

Ear/Nose/Throat

- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Bad breath or bad taste
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Eyes

- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Double/blurred vision

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Palpitations
- ☐ Shortness of breath lying
- ☐ Swelling of extremities

Respiratory

- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Asthma or wheezing

Energy

- ☐ Forgetful
- ☐ Poor concentration
- ☐ Fatigue ï Worst time of day:

Gastrointestinal

- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Painful bowel movement
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Abdominal pain

Hematology

- ☐ Bleeding or bruising
- ☐ Anemia
- ☐ Past transfusion

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Change if force of urine
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Male-testicle pain
- ☐ Female-irregular menses

Neurological

- ☐ Frequent headaches
- ☐ Light-headed/dizzy
- ☐ Convulsions
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Head injury

Musculoskeletal

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Weak muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Difficulty in walking

Skin/Breast

- ☐ Cold hands or feet
- ☐ Hives
- ☐ Rash or itching
- ☐ Hair loss
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump

Psychiatric

- ☐ Memory loss/confusion
- ☐ Nervousness/Anxiety
- ☐ Depression/Mania
- ☐ Addictive behavior

Endocrine

- ☐ Excessive thirst/urination
- ☐ Sugar cravings
- ☐ Hot/cold intolerance
- ☐ Poor sex drive
- ☐ Dry skin

Sleep

- ☐ Problems falling asleep
- ☐ Problems staying asleep
- ☐ Snore
- ☐ Restless legs

Past Medical History: Check all that apply and fill in any not listed at the end.

- ☐ *Allergies*
- ☐ *Alzheimer's*
- ☐ *Anemia*
- ☐ *Anxiety*
- ☐ *Arthritis*
- ☐ *Asthma*
- ☐ *Bleeding Disorder*
- ☐ *Blood Clot(s)*
- ☐ *Breast Disease*
- ☐ *Broken Bone*
- ☐ *Cancer – Type:*_____
- ☐ *Chronic Fatigue*
- ☐ *Chronic Pain – Where:*_____
- ☐ *Chronic Sinusitis*
- ☐ *Depression*
- ☐ *Diabetes*
- ☐ *Diarrhea*
- ☐ *Diverticulitis*
- ☐ *Eczema*
- ☐ *Emphysema*
- ☐ *Endometriosis*
- ☐ *Fibromyalgia*
- ☐ *Gout*
- ☐ *Heart Disease*
- ☐ *Hepatitis*
- ☐ *High Blood Pressure*
- ☐ *High Cholesterol*
- ☐ *Hypothyroidism*
- ☐ *Impotence*
- ☐ *Irritable Bowels*
- ☐ *Kidney Disease*
- ☐ *Low Testosterone*
- ☐ *Menopause*
- ☐ *Migraines*
- ☐ *Multiple Sclerosis*
- ☐ *Osteoporosis*
- ☐ *Panic Disorder*
- ☐ *Prostate Enlargement*
- ☐ *Reflux (GERD)*
- ☐ *Seizures*
- ☐ *Stroke*
- ☐ *Urinary Tract Infection*
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

- ☐ Appendix _____
- ☐ Gall Bladder _____
- ☐ Tonsils _____
- ☐ Sinus Surgery _____
- ☐ Tubes in Ears _____
- ☐ Hysterectomy _____
  Check: Total Partial
- ☐ Tubal Ligation _____
- ☐ Cardiac Bypass _____
- ☐ Catheterization _____
- ☐ Spinal Fusion _____
- ☐ Joint Replacement _____
- ☐ Which Joint: _____

_____
_____
_____
_____
_____
_____

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member(s) in the space provided):

- ☐ Alcoholism _____
- ☐ Allergies _____
- ☐ Alzheimer's _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Birth Defect _____
- ☐ Other _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____

_____

Do you have any allergies ï food and/ or medications (circle one)? **Yes** **No**
If yes, list and describe:

What medications (***not supplements***) are you taking now? Include non-prescription / OTC drugs.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

List all vitamins, minerals, and other nutritional supplements you are taking now. Indicate whether mg or IU (i.e. the quantity) and the form (i.e., calcium carbonate vs. calcium lactate). If you need more space please list in a separate sheet. You may bring a photocopy of the supplement container labels.

Vitamin/Mineral/ Supplement	Dosage	Frequency	Vitamin/Mineral/ Supplement	Dosage	Frequency

Substance Use:

Cigarettes	Never Used	Smoked from age _____ to _____, _____ packs per day.			
Other Tobacco	Never Used	Cigars Used from age	Pipes to ,	Snuff	Chewing Tobacco times per day.

Alcohol Never Used Estimate drinks per week: ____ Alcohol problem from age _____ to _____	
Use of other recreational drugs? Yes No If yes, specify:	

Wellness Practices:

What exercise do you do? How often? For how long?
What mind-body practice do you have (e.g. meditation, yoga, prayer)? How often?
What wellness therapies do you receive on a routine basis? Acupuncture Chiropractic Energy work Massage Other:
What are your leisure activities / hobbies?

Previous Complimentary Experiences:

☐ Acupuncture	☐ Healing Touch	☐ Massage	☐ Reiki
☐ Biofeedback	☐ Homeopathy	☐ Meditation	☐ Counseling
☐ Chiropractic	☐ Hypnotherapy	☐ Naturopathy	☐ Yoga
☐ Guided	☐ Iridology	☐ Reflexology	

Spiritual Life: Having an active spiritual or religious life is an important part of your overall health. Describe your current spiritual or religious practices. Please provide details of how often and what you do. For example, attend church, or other ceremony, group study or self-reflection.

_____

_____

Challenges and Stressors/Emotional and Psychological Well-Being

What are the top two sources of stress in your life?

1.

2.

How do you believe those sources of stress affect your daily life?

What major life decisions or changes are you facing?

Describe major losses experienced in the past 3 years:

Rate Your Happiness:

	Very Well	Good	Fair	Very Poor	N/A		Very Well	Good	Fair	Very Poor	N/A
In your job						With your attitude					
In your social Life						With your boyfriend/girlfriend					
With friends						With your children					
With sex						With your parents					
						With your spouse					

Comments:

_____

Relationships:

With whom do you live? (include: roommates, friends, partner, spouse, children, parents, relatives) Pets?
Do you feel safe in your home (circle one)? **Yes** **No**
Are you married or partnered (circle one)? **Yes** **No**
If you have children, ages of children?
Who are the most important people in your life? What is the attitude of those close to you about your health issues (circle one)? **Supportive** **Somewhat supportive** **Not supportive**

Education / Occupation:

Level of education completed:_____ Employed (circle one): **Yes** **No**
Current Occupation:_____ Describe volunteer activities:

Exercise: Please answer the following questions based on an average week.

How many times per week do you exercise?_____

List the specific exercises that you do, and how long you typically do them:

Exercise

_____

_____

_____

_____

_____

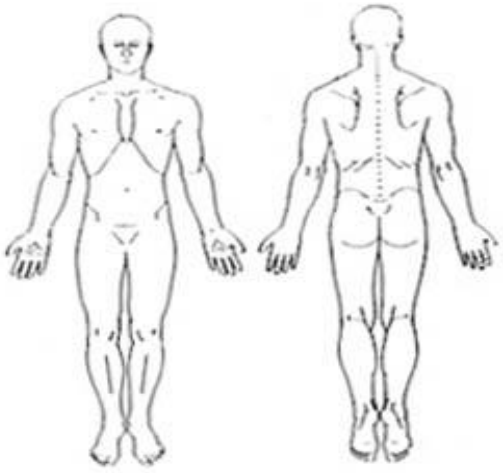
Preventative Services: Please list the date of your most recent screening procedures.

Breast Cancer:	Mammogram	_____
Cervical Cancer:	Pap smear	_____
	Colposcopy	_____
Colon Cancer:	Colonoscopy	_____
Prostate Cancer:	PSA	_____
	Digital rectal exam	_____
Diabetes:	Fasting blood sugar	_____
Heart Disease:	Fasting lipid panel	_____
Osteoporosis:	DEXA scan	_____
Carotid Artery Disease:	Carotid doppler	_____

If one of your primary problems is pain, please fill out the following:

Do you have a problem with pain that adversely affects your ability to live your life (circle one)?
Yes No

Using the diagram, please circle the location(s) where you have experienced pain in the last month.



When did the pain start?

_____

Has the pain worsened (circle one)?
Yes No

If yes, when did the pain worsen?

_____

CONSTANT or INTERMITTENT (circle one)

Please circle two numbers to indicate the <u>least and highest levels of pain</u> you have experienced in the past month:

No pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle a number to indicate the <u>average level of pain</u> that you have experienced in the last month:

No Pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please describe the quality of your pain(s), for example, burning, stabbing, achy, hopeless, electrical, tingling, pushing/ pressure, punishing and any other description that describes your experience.

_____

What makes your pain better, what makes it worse?

_____

_____

What have you tried to lessen the pain (circle all those that apply):

Acupuncture **Osteopathy** **Surgery** **Chiropractic** **Massage**

Movement Re-education (e.g. Feldenkrais) **Physical therapy** Other: _____

Dietary Information: Place a check mark next to the food / drink that applies to your current diet.
(check all that apply). Please bring a 3-day food diary with you to your first appointment. Be sure to include brand names of packaged foods so we can assess all the ingredients.

Usual Breakfast		**Usual Lunch**		**Usual Dinner**	
None/Miss		None/Miss		None/Miss	
Main Choices		Leftovers		Leftovers	
Eggs		Main Choices- Sandwiches		Main Choices ï Protein	
Oatmeal / Hot cereal		BLT		Beans	
Cold cereal		Chicken/Turkey		Fish	
Any yogurt		Fish		Poultry	
Cheese		Lettuce/tomato/mayo		Meat	
Other Choices		Meat		Any cheese	
Bacon		Vegetable/cheese		Yogurt	
Bagel		Main Choices ï Salads		Main Choices ï Carbohydrates	
Coffee		Chefôs salad		Rice	
Donut		Cesar salad		Potatoes	
Fruit		Mixed vegetable		Pasta	
Beverages		Salad dressing		Carrots	
Coffee		Any Yogurt or Cheese		Winter squash	
Tea		Beverages		Low Carb Vegetables	
Juice		Coffee		Greens	
Water		Soda		Yellow Vegetables	
Milk		Tea		Green beans	
Other: (List below)		Water		Beverages	
		Milk		Coffee	
		Dessert		Soda	
		Cookies		Tea	
		Fruit		Water	
		Other: (List below)		Milk	
				Dessert	
				Cookies	
				Fruit	
				Other: (List below)	

How many portions of the following do you consume each **week**?

Item	**Amount**	**Item**	**Amount**
Candy / Ice Cream		Slices of white bread (rolls/bagels)	
Cheese / Yogurt		Regular / diet sodas with / without caffeine	
Chocolate		Cups of decaffeinated tea / coffee	

Cups of coffee with caffeine		Cups of tea with caffeine	

List typical snack foods eaten during day and evening:

Are you on a special diet (circle one)? **Yes** **No**

If yes, circle the diet type:

ovo-lacto **diabetic** **dairy restricted** **vegetarian** **vegan** **wheat restricted**

Other_____

Is there anything else about your diet that we should know (circle one)? **Yes** **No**
If yes, please explain:

What diets have you followed in the past? Please describe your experiences (include positive and negative results)

Do you cook (circle one)? **Yes** **No**

If yes, do you make enough food at dinner to have leftovers for another meal (circle one)? **Yes** **No**

What percentage of dinner meals do you eat at home? _____

Average # of times per week you eat at fast food restaurants (e.g. Burger King, McDonalds, etc.)? _____

	Yes	No	Sometimes	Comment
Do you get sugar cravings?				
Do you get carbohydrate cravings?				
Are you an emotional or comfort eater?				
Do you binge eat or eat without control either at a meal or when eating snacks?				

Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc. (circle one)?
Yes **No**

Please describe if symptoms are associated with particular food or supplements: (Example: milk ï gas & diarrhea).

Circle any of the following items that make you feel much worse when you eat or drink a lot of them:

high fat foods **high protein foods** **refined sugar** **fried foods** **high carb foods**

Other_____

Environmental Exposures (check all that apply):

√	**Item**	√	**Item**
	Regular exposure to second-hand smoke		Do you feel worse during: spring fall summer winter
	Mercury (silver) amalgam fillings		Exposure to toxic metals at home or work? lead cadmium aluminum arsenic mercury
	Root canals? #_____		Reaction to flu shot? Yes No Describe
	# of cavities in last 2 years _____		Reaction to pneumonia (Pneumovax) shot ? Yes No Describe _____
	Bleeding gums		Travel outside US: When/Where
	Artificial joints or implants		Where did you grow up?
			Was there industrial pollution nearby?

Antibiotics / Oral Steroids (check all that apply)**:**

How often have you taken Antibiotics?	Fewer than 5 times	5 times or more	**How often have you taken oral steroids(Cortisone, Prednisone)**	Fewer than 5 times	5 times or more
Infancy/Childhood					
Teen Years					
Adulthood					

Are you interested in any of these integrative studies for personalized analysis? (please circle all that apply):

1. Cardiovascular Risk & GeneticTesting
2. Gastrointestinal infection, SIBO and Leaky Gut Testing
3. Antioxidants, Vitamins and Mineral Testing

4. Genetic Cancer Testing
5. Genetic Testing for Weight Management
6. Telomere Testing
7. Food Allergy/Sensitivities and Celiac Testing
8. Hormone Testing (Thyroid, Cortisol, Estradiol, Progesterone, Testosterone)
9. Toxin and Heavy Metal Testing
10. Immune and Inflammation Testing

I agree that the information I have provided above is accurate to the best of my knowledge.(initial)_____