

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
MR #: \_\_\_\_\_

**University of Wisconsin Hospital and Clinics**  
600 Highland Avenue • Madison, Wisconsin 53792  
621 Science Drive • Madison Wisconsin 53711  
**CLIENT INFORMATION FORM-INTEGRATIVE  
MEDICINE**

Appointment Date: \_\_\_\_\_

Time of Appointment: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Check box if you wish to receive emails regarding UW Integrative Medicine future events. This information will not be shared.

Primary care provider: \_\_\_\_\_

Referring provider: \_\_\_\_\_

*Please attach medical records as appropriate*

<b>Concern</b> (please rank by priority) <i>Example: Headache</i>	<b>Onset</b> <i>June '99</i>	<b>Frequency</b> <i>4 times/week</i>	<b>Severity</b> <i>Mild/Moderate/Severe</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are your goals for this visit?  
\_\_\_\_\_  
\_\_\_\_\_

What medical conditions do you have or have you had? *Example: Diabetes, breast cancer, high blood pressure*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any surgical procedures or injuries?

<b>What</b>	<b>When</b>	<b>What</b>	<b>When</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there specific diseases that run in your family? *Example: Diabetes, Cancer, Heart Disease*  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Please list any prescription medications that you are taking now.

Medication	Reason	Year Started	Dosage
<i>Example: Lipitor</i>	<i>High Cholesterol</i>	<i>1999</i>	<i>10 mg once a day</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergic reactions to medications?

Medication	Reaction/Intolerance
_____	_____
_____	_____
_____	_____
_____	_____

Please list any supplements, vitamins or herbs you are taking now.

Brand or Other Name (manufacturer)	Reason	Year Started	Dosage
<i>Example: Siberian ginseng</i>	<i>Energy</i>	<i>2001</i>	<i>500 mg twice a day</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Review of Systems**

Problems	System	Describe
No Yes	Cardiovascular ( <i>chest pain, high blood pressure, fainting</i> )	_____
No Yes	Respiratory ( <i>shortness of breath, wheezing</i> )	_____
No Yes	Metabolic ( <i>thyroid disorder, abnormal blood sugars, energy level, always hot or cold</i> )	_____
No Yes	Neurological ( <i>headaches, numbness, dizziness, weakness</i> )	_____
No Yes	Gastrointestinal ( <i>irregular bowel habits, cramping, heartburn</i> )	_____
No Yes	Skin ( <i>rashes, itching, dryness</i> )	_____
No Yes	Musculoskeletal ( <i>joint pain, muscle pain or spasm</i> )	_____
No Yes	Ears, Nose and Throat ( <i>hearing, sinus congestion, allergy</i> )	_____
No Yes	Vision ( <i>blurred, seeing double or spots</i> )	_____
No Yes	Difficulty sleeping, Fever, Weight loss/gain	_____
No Yes	Sexual function ( <i>poor desire, trouble having orgasm</i> )	_____

Any others we missed? \_\_\_\_\_

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Occupation

What interests/hobbies do you have?

With whom do you live? *(Include roommates, friends, partner, spouse, children, parents, relatives, and pets)*

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

In what physical activity(ies) do you participate?

What are the major stressors of your life?

What do you do to relax?

What gives you a sense of meaning and purpose? If it feels appropriate, please describe how spirituality fits into your life.

What complementary and alternative therapies have you experienced or explored?

Tobacco? Never Smoked from age \_\_\_\_\_ to \_\_\_\_\_ \_\_\_\_\_ packs per day

Alcohol? Never Estimated drinks per day \_\_\_\_\_

Other drugs? Never Type & frequency \_\_\_\_\_

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\_\_\_\_\_

**Nutrition History**

**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 servings of fruit do you eat/drink each day? \_\_\_\_\_

*Serving = 1 small piece of fruit, 1/2 cup of juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit*

How many servings of vegetables do you consume each day? \_\_\_\_\_

*Serving = 1/2 cup raw or cooked, 1 cup fresh, green leafy vegetables, 1/4 cup dried or 1 small piece*

How would you describe your relationship with food? \_\_\_\_\_

**Please return this form to UW Health Center for Integrative Medicine,  
621 Science Drive, Madison, WI 53711 ph: (608)265-0280**

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient, relationship to patient: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Pager #: \_\_\_\_\_