

Staple

8-Hole 1/4 1 3/8 c-to-c

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 and Time: _____

Primary care provider: _____ Referring provider: _____

Please attach medical records as appropriate

Concern (please rank by priority) <i>Example: Headache</i>	Onset <i>June '99</i>	Frequency <i>4 times/week</i>	Severity <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*

What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any surgical procedures or injuries?

What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there specific diseases that run in your immediate family?

Disease	Family Member	Disease	Family Member
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____
 DOB: _____
 MR # _____

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	Mood (<i>anxious, worried, tense, stressed</i>)	_____
No	Yes	Sexual function (<i>poor desire, trouble having orgasm</i>)	_____

Please list any prescription medications that you are taking now.

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

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

Tobacco? Yes No Type & frequency _____
 Alcohol? Yes No Estimated drinks per day _____
 Other drugs? Yes No Type & frequency _____

Have you ever had a problem with a substance or substances? Yes No



Staple

Patient Name:

DOB:

MR #

Social History

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

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

Profession/Vocation/Education:

How do you spend your day? _____

Describe your sleep (duration, quality, etc) _____

What do you do to relax? What interests/hobbies do you have?

In what physical activities do you participate in?

Activity	Frequency	Duration	Intensity
_____	_____	_____	_____
_____	_____	_____	_____

To whom do you turn for support in time of need? _____

What are the 3 major stressors in your life currently and in the past?

Current	Past
_____	_____
_____	_____
_____	_____

Do you have a meditation, relaxation, spiritual, reflective, or centering practice that you do?

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

What complementary and alternative therapies have you experienced or explored?

Patient Name: _____
DOB: _____
MR # _____

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: _____

Do you have any food intolerances or allergies? _____

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? _____

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? _____

Completed by: _____ Date: _____

If not patient, relationship to patient: _____

Reviewed by: _____ Date: _____ Time: _____ Pager #: _____

