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

Staple

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) *Example: Headache*	**Onset** *June '99*	**Frequency** *4 times/week*	**Severity** *Mild/Moderate/Severe*

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

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Review of Systems

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

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)	Reason	Year Started	Dosage
Example: Siberian ginseng	*Energy*	*2001*	*500 mg twice a day*

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

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

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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?

_____

_____

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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: _____

_____

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, ½ cup of juice, ½ cup canned or chopped fruit, ¼ cup dried fruit

How many servings of vegetables do you consume each day? _____

Serving = ½ cup raw or cooked, 1 cup fresh, green leafy vegetables, ¼ 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 #: _____