Date of Initial Visit: _____ Patient MRN: _____

Integrative Medicine's ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinicians during your consultations. * This is a confidential questionnaire *

Name: _____ Date of Birth: _____

Social History (continued)

Name some positive elements in your life:

1: _____ 3: _____

2: _____ 4: _____

What brings you joy? _____

Religion/Spirituality

Do you engage in regular prayer or meditation? _____

Relationships

Name: _____ Date of Birth: _____

Sleep/Relaxation

Do you have? Sleep apnea Trouble Falling Asleep Trouble Staying Asleep

How many hours of sleep do you get per night? _____ What time do you usually fall asleep? _____

Do you experience sleepiness during the day? Yes: No: Do you take naps? Yes: No:

Do you awaken refreshed? Yes: No:

Energy Level

How is your energy level? _____

Energy best at what time of day? _____

Stress/Resilience

Any significant life changes recently? Yes: No: If yes, explain: _____

Does your stress level interfere with your
enjoyment of life, your sleep, or your relationship? _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Medical Health Timeline

The purpose of the timeline is to look at all the physical, mental, and emotional events in your life, to see what impact they may have had on your current health. Circle what applies, and use the lines to add any additional details. We will review at your visit.

Your Birth: Full term/premature Vaginal delivery/C section Feeding: breast/bottle

Childhood (birth-17)

- Illness: Infections, allergies, asthma, eczema, headaches, digestive issues, sinus infections, UTI, toxic exposures, anxiety/depression
- Injuries: Fractures, sprains, dislocations, head injury, concussion29)
- Surgeries: Appendectomy, tonsillectomy, orthopedic surgery
- Emotional Events: Drug/alcohol use in the house when you were growing up, mental illness of parent or sibling, divorce of your parents, abuse (physical, sexual, emotional), significant losses, bullying, significant moves, pregnancy

Additional Details:

_____

_____

_____

Young adult (18-29)

9)

Name: _____ Date of Birth: _____

Medical Health Timeline (continued)

Adult (30-59)

- Illness: Infections, allergies, asthma, eczema, headaches, digestive issues (reflux, IBS, IBD), sinus infections, UTI, cancer, toxic exposures, diabetes, hypertension, stroke, arrhythmia, elevated cholesterol, menopause, neurologic issues, anxiety/depression
- Injuries: Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- Surgeries: Appendectomy, cholecystectomy tonsillectomy, orthopedic surgery, hysterectomy
- Emotional Events: College graduation, graduate degree, marriage, divorce, childbirth, miscarriage, abortion, significant moves, significant losses, abuse/assault, job loss, retirement

Additional Details:

_____

_____

_____

Adult (60+)

- Illness: Infections, allergies, asthma, eczema, headaches, digestive issues (reflux, IBS, IBD), sinus infections, UTI, cancer, toxic exposures, diabetes, hypertension, stroke, arrhythmia, elevated cholesterol, neurologic issues, anxiety/depression
- Injuries: Fractures, sprains, dislocations, head injury, concussion, back/neck injury
- Surgeries: Appendectomy, cholecystectomy tonsillectomy, orthopedic surgery, hysterectomy
- Emotional Events: Educational degree, marriage, divorce, significant moves, significant losses, abuse/assault, job loss, retirement

Additional Details:

_____

_____

_____