NorthShore University HealthSystem

Integrative Medicine Intake Form

Please bring this completed form and a copy of your medical records to your appointment, or FAX to 847-657-3521 or MAIL to 2400 Chestnut, Glenview IL 60026.

Name	Age	Appointment date	Birth date

Contact # ______________________ Email ______________________

How were you referred to our center?

Concern (Please rank by priority) *Example: Headaches*	Onset *Example: June 2000*	Frequency *Example: 4x/week*	Severity *Example: 5 out of 10 or mild/mod/severe*

What are your goals for this visit?

Your Past Medical History- include date or year of diagnosis. You may also attach a separate list.
Example: Reflux/heartburn - started 2003; had scope procedure 8/05 w/ normal result; ***Please be succinct*.**

1. ______
2. ______
3. ______
4. ______
5. ______

Family Medical History (indicate type of disease)	Family Medical History
Mother: ______ Father: ______ ______	______ ______ ______

Surgery (major/minor procedures), when, where	Injuries *Example: Car accident 1995- head injury*

Tobacco ○ None ○ Smoked cigarettes from age ______ to ______ ______ packs per day
Check if you've used or use the following: ○ Cigars ○ Chewing tobacco

Alcohol ○ None ○ Estimated drinks per week ______ Preferred drink(s)______

Recreational substances ○ None ○ Type(s) and frequency ______

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Allergic reaction/intolerances to medications *Example: penicillin-hives*	**Allergic reaction/intolerances (foods, environment)** *Example: cow's milk-bloating*

Medications (prescription & over the counter) *or attach your own list*	Dosage & frequency	Reason	Taking for how long?	Cost/month (optional)

Herbs, vitamins & supplements *or attach your own list* *Please include brand name*	Dosage & frequency	Reason	Taking for how long?	Cost/month (optional)

Occupation (if retired, what was your previous occupation?) ______________________
How many hours do you work per week? (i.e. 40 hours/week, mostly night shifts) ______________________

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

Name (optional)	Age	Relationship	Name (optional)	Age	Relationship

What physical activities do you participate in & how often? ______________________
Do you belong to a gym? ______ **Where do you usually exercise?** ______________________

Hobbies/interests: ______________________

Sleep: # hours/night ______________ **Describe your sleep:** ______________________
Any trouble falling asleep, staying asleep or both? ______________________

What are the major stressors in your life? ______________________
____

Spiritual or religious practice, past & present (if applicable) ______________________

What prior experiences have you had with complementary & alternative medicine? ______________________
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Nutrition History

Are you currently on a special diet? If so, please describe: ____________________

How many servings of fruit do you usually eat/drink each day? ____________________
(Serving = 1 small piece of fruit, ½ cup fruit 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 vegetables, 1 cup fresh, green leafy vegetables, ¼ cup dried vegetables or 1 small piece)

How much water do you drink on a typical day? ____________________
Example: Four 16-ounce bottles water/day

How often do you drink per day:
Soda (diet or regular) __________ # Other sugary drinks or 100% fruit juice: __________
Cups of coffee per day __________ # cups of tea per day __________

Please indicate the number of times or servings you consume during an average week:

How often do you eat the following per week:	**# servings or # times** *(1 serving meat = 3 ounces cooked meat, poultry or fish = a deck of cards sized piece)*
Red meat (beef, pork, lamb, veal, etc.)	
Fish/seafood	
Poultry (chicken, turkey, duck, quail, etc.)	
Eggs	
Animal-sourced dairy (cow/sheep/goat/etc.) milk,yogurt,kefir,cheese,cottage cheese, etc.	
Soy (tofu, tempeh, edamame)	
Beans/legumes - including peanuts	
Nuts, seeds or nut butters	
Protein powder or bars	
Chips or crackers	
Desserts and other sweets	

How often do you eat out at restaurants or fast food places per week? ____________________
Which restaurants do you typically visit? ____________________

Your physician team (fill in where applicable):
Month/year of your last physical: ____________________

Primary care physician: ____________________
OB/Gyne physician: ____________________
Specialty physician: ____________________
Specialty physician: ____________________
Specialty physician: ____________________

Others (psychotherapist, acupuncturist, massage/energy therapist, nutritionist, chiropractor, naturopath, etc.)

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Note: All information on this form is kept confidential. If there is anything you wrote on this intake form that you do not want included in the medical record, please note this and let the physician know not to include it in the progress notes. This information is to help assist the physician become familiar with the multiple dimensions of your health in order to make the most efficient use of our limited time during the office visit. We may not be able to cover every aspect of this questionnaire, but it is important information for future visits.