



## Integrative Health Evaluation

### Background Information

Date:	Name:	Date of Birth:
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### Health Concerns

	Concern Ex: PMS	Onset Ex. Age 14	Symptoms Ex: Moody, bloating, etc.	Treatments Ex: B vits, acupuncture, etc.
1				
2				
3				
4				

What are your goals for this visit?

- 1.
- 2.
- 3.

Do you have any allergies to medications, foods, pollens, etc.?

Allergen/Triggers (medication, food, etc.)	Reaction

Do you have any disabilities?  No  Yes (Describe):

**Have you ever had surgery or had any injuries? (Include major dental work)**

Surgery or injury	How treated	When

**List any prescription medications you are taking:**

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

Do you cut back or not take any medications because of costs or side effects?

No  Yes

**List any over the counter medications you are taking:**

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

**List any herbs, supplements or vitamins you are taking: (Give Brand)**

Supplement	Reason for taking	Dose/Times per day	Year started	Side Effects

## Use of Complementary or Alternative Therapies

Type	Never Tried	Tried	Use Currently	Not for Me	Interested In
Massage					
Acupuncture					
Chinese herbs					
Other herbs					
Homeopathy					
Chiropractic					
Osteopathy					
Nutrition					
Mind-Body (Hypnotherapy, Biofeedback, etc...)					
Reiki					
Other energy therapies (healing touch, polarity, etc...)					
Ayurveda					
Others:					

## Substance Use History

How much alcohol (beer, wine, liquor) do you drink -

each day? \_\_\_\_\_ each week? \_\_\_\_\_ None

How much tobacco (cigarettes, cigars, pipe, chewing tobacco) do you use -

each day? \_\_\_\_\_ each week? \_\_\_\_\_ None

How much caffeine (cola drinks, coffee, strong tea) do you drink -

each day? \_\_\_\_\_ each week? \_\_\_\_\_ None

Do you currently use drugs (Ex. Marijuana, cocaine, crack, heroin, speed, ecstasy, etc.)?

No  Yes What kind and how often? \_\_\_\_\_

In the past?  No  Yes How long ago? \_\_\_\_\_

What kind and how often? \_\_\_\_\_

Does anyone in your family have problems with drugs or alcohol?  No  Yes

Who? \_\_\_\_\_

Have you been in a drug or alcohol recovery program?  No  Yes

Do you want to quit using tobacco, alcohol or drugs?  No  Yes

Would you like advice, support or medicine to help you quit?  No  Yes



## Family History

Problem	Do you have now or in the past?	Family member has had? (list who)	How treated?
Heart disease			
High blood pressure			
Stroke			
Cancer			
Diabetes			
High cholesterol			
Mental health problems such as depression			
Colon polyps or colon cancer			
Other problems			

Were you adopted?  No  Yes

If so, do you have any medical knowledge about your biological family?  No  Yes

### Are there any medical conditions that run in your family?

Problem	Family member(s)

### Health Status of Immediate Family:

Family Member	Age	Health Problem
Mother:		
Father:		
Siblings:		
Children:		
Spouse/Significant Other:		

## Preventive Health

**Do you participate in any physical activity or exercise?** Example: walking, going to the gym, cleaning houses, sports, etc.

Activity	Amount of time/day or week

Do you do any type of flexibility exercises such as Tai Chi, Yoga or stretching?

No    Yes

Do you do any type of resistance or weight training?    No    Yes

Are you interested in being more physically active?    No    Yes

What types of physical activity would you like to be involved in?

What would you like to achieve from being physically active?

What keeps you from being physically active?

Are there specific things that you do in order to maintain your health?    No    Yes

What are they?

Are there specific ways that you monitor your body or your health?    No    Yes

What are they?

If you feel as if you are “coming down” with something, are there specific things that you do or don’t do to take care of yourself?    No    Yes   What are they?

Name three things you know you should be doing for your health but are not currently doing.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Nutrition History

Are you currently on a special diet?  No  Yes If yes, describe:

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Have you ever felt out of control of your eating habits?  No  Yes

Have you struggled with frequent vomiting, making yourself vomit or eating so little over periods of time that you or others were worried?  No  Yes

Your current Weight\_\_\_\_\_ Height\_\_\_\_\_ BMI \_\_\_\_\_

In the last year, have you experienced significant weight loss or gain?  No  Yes

If yes, describe: \_\_\_\_\_

### List all the foods you have eaten in the last 24 hours

<b>Breakfast</b> Time eaten: _____ Where eaten: _____	List Foods/Beverage	List Foods/Beverage
<b>Lunch</b> Time eaten: _____ Where eaten: _____	Foods/Beverage	Foods/Beverage
<b>Dinner</b> Time eaten: _____ Where eaten: _____	Foods/Beverage	Foods/Beverage
<b>Snacks</b> Time eaten: _____ Time eaten: _____	Foods/Beverage	Foods/Beverage

Is this a typical day for you?  No  Yes If not, how is it different?

Who usually prepares your meals? \_\_\_\_\_

Do you usually eat alone or with someone? \_\_\_\_\_

What percentage of the food you eat is organic? \_\_\_\_\_%

Please check which column most accurately describes how often you consume a serving of the following foods/beverages:

Servings of:	None	Once a week	3-5 x a week	Once a day	2-3x a day	3-5x a day	5-9x a day
6 oz water							
½ cup fruit or vegetable							
whole grain cereal, bread, brown rice, wheatberry, quinoa, oats							
beans/legumes							
green/black/white tea							
olive oil, canola oil, olives, avocados							
small handful of nuts							
4 oz soy protein (tofu, tempeh, soy milk)							
clove of garlic							
Fish (salmon, tuna etc.)							
flaxseed							
small handful of seeds							
dark chocolate							
poultry							
dairy products							
white potatoes, rice or bread							
caffeinated coffee, cola							
diet drinks							
butter							
vegetable oil							
margarine							
something from a box with a long shelf life							
red meat							
alcohol							
fried foods							
sweets/candy							
fast food							

**Are there any types of foods that you crave?**

Food	Why or When?

**Are there any types of foods that you do not eat?**

Food	Why?

**Do you have problems with any of the following?**

Constipation  No  Yes Diarrhea  No  Yes Bloating/gas?  No  Yes

**Social History**

**Do you live with anyone? If so, who? Please include pets.**

Name	Age	Relationship

Marital/Partner Status:

Past (e.g. married twice) \_\_\_\_\_

Current (Single, Married, Partnered, divorced.....) \_\_\_\_\_

With whom do you have the most significant relationships?

\_\_\_\_\_

Closest? \_\_\_\_\_

Most problematic? \_\_\_\_\_

With whom do you share your feelings? \_\_\_\_\_

Who would you call for a favor? \_\_\_\_\_

Do you belong to a group or community? \_\_\_\_\_

Have you ever been in a support program for a medical condition?  No  Yes

Describe: \_\_\_\_\_

Do you have enough money to meet your needs?  No  Yes

What do you do with your time? Example: work, school, care for home or children, etc.

How much TV do you watch each day? \_\_\_\_\_ hours

Have you served in the armed forces?  No  Yes If yes, give details:

What interests/hobbies do you have?

Do you do any volunteer work?  No  Yes If yes, describe:

### Abuse

Have you ever been abused emotionally (treated in a mean, nasty or cruel manner) by your partner or someone important to you?  No  Yes If yes, by whom?

Within the last year, have you been hit, slapped kicked or otherwise physically hurt by someone?

No  Yes If yes, by whom? \_\_\_\_\_

Within the last year, has anyone forced you to have sexual activities?  No  Yes

If yes, whom? \_\_\_\_\_

Are you afraid of your partner or anyone listed above?  No  Yes

If yes, of whom? \_\_\_\_\_

Would you like to discuss these things with me or someone else?  No  Yes

### Sexual Health

Do you have sex with: Men  Women  Transgender  No one

Age of first intercourse: \_\_\_\_\_ Number of partners in the past year: \_\_\_\_\_

What type of sex do you have:  Vaginal  Anal  Oral (Check all that apply)

Have you ever had sex with someone who...

has HIV?  No  Yes uses needles?  No  Yes is a bisexual?  No  Yes

Do you use safer sex protection?  No  Yes

Do you use any form of birth control?  N/A  No  Yes If yes, what ?

Are you happy with this method?  No  Yes

Have you ever used:

Condoms  The pill  Depo shot  Diaphragm  Cervical cap  Norplant

Spermicides  Withdrawal  Female condom  IUD  Natural family planning

Have you ever had:

Chlamydia  Gonorrhea  Genital Warts/HPV  Herpes  Syphilis  HIV

Are you happy with your sex life?  No  Yes Comments:

If there was one thing you could change about your sex life, what would it be?

Have you ever used any sexual enhancement drugs (Viagra, Levitra, Cialis, etc.) or herbals?

No  Yes Describe;

## Women's Health History

Age periods began: \_\_\_\_\_ Age periods stopped: \_\_\_\_\_ **Last menstrual period** \_\_\_\_\_

How often do you get your period? \_\_\_\_\_ days. Is it regular?  No  Yes

How long does (did) it last? \_\_\_\_\_ days

Do you bleed between periods?  No  Yes

Do you have bad cramps?  No  Yes

If yes, are you able to manage your cramps?  No  Yes

Do you have premenstrual symptoms?  No  Yes Describe:

Do you have menopausal symptoms?  No  Yes Describe:

Do you have pain or bleeding with sex?  No  Yes

Any history of fibroids, endometriosis, ovarian cysts or other reproductive health problems?

No  Yes Describe:

**When was your last Pap smear?** \_\_\_\_\_ Was it normal?  Yes  No

Have you ever had an abnormal Pap smear?  No  Yes When? \_\_\_\_\_

Results \_\_\_\_\_

Did you have: (check all that apply)

Colposcopy \_\_\_\_\_ Treatment \_\_\_\_\_ Repeat Pap smears normal \_\_\_\_\_

**When was your last mammogram?** \_\_\_\_\_ Was it normal?  Yes  No

Have you ever had an abnormal mammogram?  No  Yes If yes, When \_\_\_\_\_

Results \_\_\_\_\_ Where performed \_\_\_\_\_

Further testing \_\_\_\_\_

Do you have breast pain, discharge, skin changes or any other problems?  No  Yes

Have you had any breast surgeries?  No  Yes Describe:

Have you ever had:  Pelvic inflammatory disease (PID)  Frequent Yeast Infections

Frequent Bacterial Vaginal (BV) Infections

Number of:

pregnancies: \_\_\_\_\_ births: \_\_\_\_\_ miscarriages: \_\_\_\_\_ abortions: \_\_\_\_\_ living children: \_\_\_\_\_

Any problems with your pregnancies?  No  Yes If yes, what?

Have you had problems getting pregnant?  No  Yes If yes, describe:



