Columbus Integrative Family Medicine Center

Intake Form

Name: _____ Today's Date: _____

Birthdate: _____

How did you hear about us? (Circle all that apply)

Doctor Family Member Friend Internet Other: _____

What is your goal(s) for this visit? _____

	Symptoms/Diagnosis	When did it start?	Frequency	Severity (1=mild, 10=severe)
1.				
2.				
3.				
4.				
5.				

How have you tried to resolve the above symptoms/diagnoses?

	Symptom/Diagnosis	What did you try?	How did it work?
1.			
2.			
3.			
4.			
5.			

Please bring this form to your office visit, fax to 614-515-5757 and/or mail to Columbus Integrative Family Medicine Center at 453 Waterbury Ct, Gahanna, OH 43230 before your office visit

What complementary/alternative medicine modalities have you tried in the past? (Circle all that apply)

Acupuncture/Traditional Chinese Medicine Homeopathy

Massage Naturopathy

Ayurveda Chiropractic

Other: _____

Do you have a family history of: Cancer Heart Disease Diabetes Arthritis

Neurological Mental Illness Dementia Addiction Other_____?

Prior Surgeries (if more than 4 please attach list):

Date Type of Surgery

1._____

2._____

3._____

4._____

Taking any medications, vitamins, herbs and/or supplements? Yes No

Name Dose Frequency (If more than 5 please attach list)

1._____

2._____

3._____

4._____

5._____

Any medication allergies? Yes No

Name Reaction

1._____

2._____

3._____

4._____

5._____

Do you currently have any of the following: (**Circle all that apply** and **mark Yes or No**)

Constitutional	o Dizziness, passing out, seizures, fatigue	Yes No
Eyes	o Eye problems (vision changes, dryness, floaters)	Yes No
ENT	o Ear problems (hearing, wax, ringing, pain) o Nose problems (breathing, stuffiness, sense of smell) o Throat problems (sore throat, difficulty swallowing)	Yes No Yes No Yes No
Mouth	o Mouth problems (pain, dental, sores, sense of taste)	Yes No
Cardiovascular	o Heart problems (heart attack, heart rate, blood pressure) o Vein, circulatory problems (varicose, edema, blockage)	Yes No Yes No
Respiratory	o Lung disorders (asthma, breathing difficulty, emphysema)	Yes No
Gastrointestinal	o Digestive concerns (pain, bloating, indigestion, reflux) o Diarrhea or constipation o Number of daily bowel movements:_____	Yes No Yes No
Genitourinary	o Kidney, urination (frequency and/or pain), genital problems o Get up at night to urinate o Number of times each night:_____	Yes No Yes No

Musculoskeletal	o Bone, joint, structural problems, arthritis o Recent wounds, injuries, pain, muscle cramps, spasms	Yes No Yes No
Skin	o Skin problems (dryness, rash, bumps, wounds)	Yes No
Neurologic	o Numbness, tingling, hands and feet cold during the winter o Forgetfulness, mental clarity, memory	Yes No Yes No
Mental Health	o Mood, depression, affect, sadness, grief, anxiety	Yes No
Hematology/ Lymph	o Blood disorders, hepatitis, HIV/AIDS, herpes	Yes No
Allergy/Immune	o Allergies:_____, o Lupus, Scleroderma, Immune disorders	Yes No Yes No
Endocrine	o Thyroid problems, Diabetes, low sugar, under/overweight	Yes No

Diet:

1. How is your appetite? Excellent Good Poor, why?_____
2. How often do you eat? 3 meals + snacks/day 3 meals 1-2 meals Snack only
3. How often do you skip meals? Never Daily Occasionally, why_____
4. How satisfied are you with your eating habits? Not at all Somewhat Very
5. How satisfied are you with your current weight? Not at all Somewhat Very
6. Do you consider your diet to be healthy? Yes No, why? _____
7. Are you on a special diet? Yes, why?_____ No
8. Do you have food allergies? Yes, _____ No

Education, Exercise and Life Style:

9. What is your highest level of education completed?

   Grade School High School Some College College Graduate School

   Other: _____

10. With whom do you live? Spouse Partner Parent Sibling Roommate

    Children Other: _____

11. Are you satisfied with your current living situation? Yes No

12. Do you feel you have an adequate support system? Yes No

13. How do you spend your free time? (Interests/Hobbies)_____

14. What is your current occupation? _____ Years_____

15. Are you satisfied with your occupation/employment status? Yes No

16. Any toxic chemical exposures in past? Yes, _____ No

17. When in your life did you last feel well? _____

18. What was different then? _____

19. Do you exercise? Yes, how often_____week _____ minutes No, why not?_____

20. What is your exercise level? Scale 1-10 (1 low, 10 high)_____

Do you use:

21. Medications to aid sleep? Yes, what and how often:_____ No

22. Tobacco products? Yes, how often:_____ No

23. Alcohol? Yes, how often:_____ No

24. Mood-altering drugs? Yes, what and how often:_____ No

25. Pain Medications? Yes, what and how often:_____No

26. If yes, have you tried to cut down on your use of these substances? Yes No

27. Does it bother you when anyone questions your use of these substances? Yes No

28. Do you ever feel guilty for using these substances? Yes No

29. Have you ever used these substances to steady yourself in the morning? Yes No

30. Have you ever sought counseling or professional help? Yes No

31. Did you find it helpful? Yes No, why not?_____

32. Are you currently working with a counselor, therapist, clergy or life coach? Yes No

33. If yes, which profession and for how long? _____

34. What are your major stressors? _____

35. How do you handle stress? Poorly Fair Good Well

36. How is your memory? Poor Fair Good Excellent

37. How clear is your thinking? Poor Fair Good Excellent

38. How is your rate of overall functioning? Poor Fair Good Excellent

In the space allotted, you may provide any additional health concerns or pressing issues.