Parkview Medical Group • Center for Integrative Medicine

The practice of Integrative Medicine requires the understanding of clients as a whole: Mind, body and spirit. Please take the time to fill out this intake form as completely as possible. This form will provide a foundation for your experience at the Center, as it will help to stimulate areas that may need special attention during your visit.

Name: ______________________________ Date of Birth: ______________

Today's Date: ______________

Referral Source: ❑ Physician: Dr.______________________ ❑ Self

Primary Care Physician: ______________________________

Goals: Please list the reasons you have come to the Center for Integrative Medicine.

____

____

____

____

Past Medical History: Check all that apply and fill in any not listed at the end.

- ❑ Allergies
- ❑ Alzheimer's
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Clot(s)
- ❑ Breast Disease
- ❑ Broken Bone
- ❑ Cancer – Type:______________
- ❑ Chronic Fatigue
- ❑ Chronic Pain – Where:__________
- ❑ Chronic Sinusitis
- ❑ Depression
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Diverticulitis
- ❑ Eczema
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Hypothyroidism
- ❑ Impotence
- ❑ Irritable Bowels
- ❑ Kidney Disease
- ❑ Low Testosterone
- ❑ Menopause
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Osteoporosis
- ❑ Panic Disorder
- ❑ Prostate Enlargement
- ❑ Reflux (GERD)
- ❑ Seizures
- ❑ Stroke
- ❑ Urinary Tract Infection
- ❑ ______________
- ❑ ______________
- ❑ ______________

Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

- ❑ Appendix ______________
- ❑ Gall Bladder ______________
- ❑ Tonsils ______________
- ❑ Sinus Surgery ______________
- ❑ Tubes in Ears ______________
- ❑ Hysterectomy ______________
  Check One: ❑ Total ❑ Partial
- ❑ Tubal Ligation ______________
- ❑ Cardiac Bypass ______________
- ❑ Catheterization ______________
- ❑ Spinal Fusion ______________
- ❑ Joint Replacement ______________
  Which Joint: ______________
- ❑ ______________
- ❑ ______________
- ❑ ______________
- ❑ ______________
- ❑ ______________
- ❑ ______________

10515 Illinois Road • Fort Wayne, IN 46814

CLIENT INTAKE FORM

Review of Current Symptoms: Please check any symptoms or concerns you have had in the last several months.

Constitutional
- ❑ Good general health
- ❑ Recent weight change
- ❑ Headaches
- ❑ Fever

Ear/Nose/Throat
- ❑ Hearing loss or ringing
- ❑ Earaches or drainage
- ❑ Sinus problems
- ❑ Nosebleeds
- ❑ Bad breath or bad taste
- ❑ Sore throat or voice change
- ❑ Swollen glands in neck

Eyes
- ❑ Eye disease or injury
- ❑ Wear glasses/contacts
- ❑ Glaucoma
- ❑ Double/blurred vision

Cardiovascular
- ❑ Chest pain or pressure
- ❑ Palpitations
- ❑ Shortness of breath lying flat
- ❑ Swelling of extremities

Respiratory
- ❑ Chronic or frequent cough
- ❑ Shortness of breath
- ❑ Asthma or wheezing

Energy
- ❑ Forgetful
- ❑ Poor concentration
- ❑ Fatigue – Worst time of day: ___________________

Gastrointestinal
- ❑ Loss of appetite
- ❑ Nausea or vomiting
- ❑ Diarrhea
- ❑ Painful bowel movement
- ❑ Constipation
- ❑ Rectal bleeding
- ❑ Abdominal pain

Hematology
- ❑ Bleeding or bruising
- ❑ Anemia
- ❑ Past transfusion

Genitourinary
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Change if force of urine
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Male-testicle pain
- ❑ Female-irregular menses

Neurological
- ❑ Frequent headaches
- ❑ Light-headed/dizzy
- ❑ Convulsions
- ❑ Numbness/tingling
- ❑ Tremors
- ❑ Head injury

Musculoskeletal
- ❑ Joint pain
- ❑ Joint stiffness/swelling
- ❑ Weak muscles or joints
- ❑ Muscle pain or cramps
- ❑ Back pain
- ❑ Difficulty in walking

Skin/Breast
- ❑ Cold hands or feet
- ❑ Hives
- ❑ Rash or itching
- ❑ Hair loss
- ❑ Varicose veins
- ❑ Breast pain
- ❑ Breast lump

Psychiatric
- ❑ Memory loss/confusion
- ❑ Nervousness/Anxiety
- ❑ Depression/Mania
- ❑ Addictive behavior

Endocrine
- ❑ Excessive thirst/urination
- ❑ Sugar cravings
- ❑ Hot/cold intolerance
- ❑ Poor sex drive
- ❑ Dry skin

Sleep
- ❑ Problems falling asleep
- ❑ Problems staying asleep
- ❑ Snore
- ❑ Restless legs

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following (Please state the family member(s) in the space provided):

- ❑ Alcoholism ___________________
- ❑ Allergies ___________________
- ❑ Alzheimer's ___________________
- ❑ Anemia ___________________
- ❑ Asthma ___________________
- ❑ Birth Defect ___________________
- ❑ Bleeding Disorder ___________________
- ❑ Cancer:
  - Member/Type: ___________________
  - Member/Type: ___________________
  - Member/Type: ___________________
- ❑ Depression ___________________
- ❑ Diabetes ___________________
- ❑ Epilepsy ___________________
- ❑ Heart Disease ___________________
- ❑ High Blood Pressure ___________________
- ❑ High Cholesterol ___________________
- ❑ Kidney Disease ___________________
- ❑ Stroke ___________________
- ❑ ___________________
- ❑ ___________________
- ❑ ___________________

Allergies:

Are you aware of any drug allergies? ❑ Yes ❑ No

If Yes, please list the drugs and the reaction you had: ______________________

____

____

____

Environmental allergies?

____

____

Food allergies?

____

____

Social History:

Who lives at home with you? ______________________

____

Occupation. Please list what you do, approximately how many hours per week and your level of satisfaction:

____

____

____

Has this or any job put you around strong chemicals or smoke? ❑ Yes ❑ No

Tobacco: ❑ Yes ❑ No If Yes, how many per day:________________ How many years: ____________

Currently smoking: ❑ Yes ❑ No If quit, how long ago:______________

Smoke exposure at home: ❑ Yes ❑ No

Alcohol: ❑ Yes ❑ No If Yes, how many drinks per week:____________ How many years: ____________

Drug use (state which drug and if currently using): ______________________

Medications: Please attach a separate list if you have one, or if you need extra space.

Name	Dose	How Often? (if as needed, state average use)

Supplements: Please be as specific as possible. In addition to listing, please bring all supplements to your appointment.

What Is It	Manufacturer	Dosage	How Many Per Day	Why You Take It

Stress: Stress and the management of stress is very important to your overall health.

Describe the symptoms that you feel when you are under stress: ______________________________

____

____

Describe activities or techniques you use to relieve stress: ______________________________

____

____

Spiritual Life: Having an active spiritual or religious life is an important part of your overall health.

Describe your current religious practice (Please provide details as to how often and what you do. For example, do you attend church or other ceremony? Any small group study?):

____

____

____

Previous Complimentary Experiences:

- ❑ Acupuncture
- ❑ Biofeedback
- ❑ Chiropractic
- ❑ Guided Imagery
- ❑ Healing Touch
- ❑ Homeopathy
- ❑ Hypnotherapy
- ❑ Iridology
- ❑ Massage
- ❑ Meditation
- ❑ Naturopathy
- ❑ Reflexology
- ❑ Reiki
- ❑ Psychological Counseling
- ❑ Yoga

Additional Dietary Information: In addition to filling out your two day diet history, please provide honest answers to these questions based on a typical day.

Cups of regular coffee: ____________ Regular soda: ______________ Flavored water or Propel: ___________

Cups of decaf coffee: _____________ Diet soda: _________________ Meals per day: ___________________

Cups of regular tea: ______________ Crystal Light: _______________ Meals made at home: _______________

Cups of decaf tea: _______________ Artificial Sweetener packs (Splenda or others): _____________________

Exercise: Please answer the following questions based on an average week.

How many times per week do you exercise?________________________

List the specific exercises that you do, and how long you typically do them:

Exercise	Duration

Preventative Services: Please list the date of your most recent screening procedures.

Breast Cancer: Mammogram ____________________________

Cervical Cancer: Pap smear ____________________________

Colposcopy ____________________________

Colon Cancer: Colonoscopy ____________________________

Three stool test ____________________________

Prostate Cancer: PSA ____________________________

Digital rectal exam ____________________________

Diabetes: Fasting blood sugar ____________________________

Heart Disease: Fasting lipid panel ____________________________

Osteoporosis: DEXA scan ____________________________

Carotid Artery Disease: Carotid doppler ____________________________