ARIZONA CENTER FOR Integrative Medicine

Patient Intake Form

Return Completed Form to AzCIM at least two weeks prior to your appointment via Fax or Mail:

FAX:
Attn: Dr. Randy Horwitz
520-626-6484
OR
Attn: Dr. Victoria Maizes
520-626-6484

MAIL:
Attn: Clinic
Arizona Center for Integrative Medicine
PO Box 245153
Tucson, AZ 85724

If you need to cancel or change your appointment, please call 520-694-8888 as soon as possible.

PLEASE PRINT LEGIBLY

Name:	Date of Birth:	Appointment Date/Time:
Address:	City:	State, Zip:
Email:	Phone:	Phone:

Which physician are you seeing? (circle one)

Dr. Randy Horwitz Dr. Victoria Maizes

What are your goals for this visit?

Concerns (please rank by priority) *Example: Headache*	**Onset** *June 2010*	**Frequency** *4 times/week*	**Severity** *mild/mod/severe*

Past Medical History

Conditions	Have you ever experienced this?	Has a close family member?	Please explain.
Cancer (type:_____)	Yes_____ No_____	Yes_____ No_____	
Depression	Yes_____ No_____	Yes_____ No_____	
Diabetes	Yes_____ No_____	Yes_____ No_____	
Digestive Disorders	Yes_____ No_____	Yes_____ No_____	
Heart Disease	Yes_____ No_____	Yes_____ No_____	
High Blood Pressure	Yes_____ No_____	Yes_____ No_____	
High Cholesterol	Yes_____ No_____	Yes_____ No_____	
Lung Disease (asthma, etc.)	Yes_____ No_____	Yes_____ No_____	
Liver Disease	Yes_____ No_____	Yes_____ No_____	
Seizures	Yes_____ No_____	Yes_____ No_____	
Stroke	Yes_____ No_____	Yes_____ No_____	
Thyroid Disease	Yes_____ No_____	Yes_____ No_____	
Other:_____	Yes_____ No_____	Yes_____ No_____	
Other: _____	Yes_____ No_____	Yes_____ No_____	
Other: _____	Yes_____ No_____	Yes_____ No_____	
Other: _____	Yes_____ No_____	Yes_____ No_____	

Do you know if you have ever been exposed to harmful environmental substances?

_____

_____

Please list any medications to which you are allergic:

Medication	Reaction/Intolerance

Please list any prescription medications you are taking now.

Please list any supplements, vitamins or herbs you are taking now.

Brand or Other Name (manufacturer) *Example: St. John's Wort*	Reason *Feeling Down*	Year Started *2010*	Dosage *3 caps*

Have you had any injuries or surgical procedures?

What	When	Comments

Personal/Social History

Tobacco? Yes No Type and frequency: _____

Alcohol? Yes No Estimated drinks per day:_____ Per Week: _____

Other drugs? Yes No Type and frequency: _____

What is your occupation?

What are your hobbies and interests?

How do you spend your day?

With whom do you live? (include roommates, spouse, children, relatives, pets, etc.)

Name	Age	Relationship	Name	Age	Relationship

In what physical activities do you participate?

Activity	Frequency	Duration	Intensity

What do you do to relax?

What are three major stressors in your life?

Do you have a meditation, relaxation, spiritual, reflective, or centering practice that you do?

What gives you a sense of meaning and purpose? If it feels appropriate, describe how spirituality or religion fits into your life, or how it has in the past.

What prior experiences have you had with complementary and alternative medicine?

Nutrition Diary

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages, and condiments.

Is this a typical day? If not, why not?

Do you have any food allergies or intolerances?

Are there any types or groups of food you crave or eat a lot?

Are there any types or groups of food you dislike or rarely eat?

What do you drink on a typical day?

What type of oil do you cook with? What spreads do you add to your food?

How many servings of fruit do you eat/drink each day? _____
Serving = 1 small piece of fruit, ½ cup of juice, ½ cup canned or chopped fruit, ¼ cup dried fruit

How many servings of vegetables do you eat/drink each day? _____
Serving = ½ cup raw or cooked, 1 cup fresh, green leafy vegetables, ¼ cup dried or 1 small piece

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

How would you describe your relationship with food?

Do you have any other comments or things you would like to discuss?

Completed by: _____ Date: _____

If not patient, relationship to patient: _____