

Pillsbury House Integrated Health Clinic: Welcome to Our Clinic

Today's date: _____

Name _____ Date of Birth _____ Male Female Other

Address _____ City/State/Zip _____

Phone #:(H) _____ (W) _____ (Cell) _____ Occupation _____

E-mail: _____ Current Health Care Provider Clinic & Doctor(s): _____

Emergency Contact & Phone #: _____ Nationality/Race: _____

Hispanic/Latino African-American White Asian Mexican Other _____

How did you hear about our clinic?

What is the main reason for your visit today?

Concern (Please rank by priority) Example: Headaches	Onset	Frequency	Severity
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for the visit? Do you have a preference for a specific healing modality TODAY (ex. Chiropractic, acupuncture)?

Current Medications/Over the Counter/Supplements/Birth Control (last 3 months, dose, how many, timing):

Current Weight _____ Weight 1 year ago _____ Maximum Weight _____

List all foods and drinks you have consumed in the last 24 hours:

Alcohol: # of drinks (e.g. beer, wine, etc)? none 1-2 a month 1-2 a week 1-2 a day 3 or more a day Other _____

Caffeinated drinks: none 1-2 a month 1-2 a week 1-2 a day 3 or more a day Other _____

Do you smoke cigarettes? Yes / No. If yes, how many pack(s) per day? _____ If you used to, when did you quit? _____

Name: _____ Today's date: _____

What is your activity level and kind of activity during an average day? (e.g. walking, playing basketball, etc.)

How important is exercise and fitness to you? Circle one: Not Moderately Very

How many hours of sleep do you get each night? _____

Do you fall asleep during the day when you were not trying? _____

How long does it usually take you to fall asleep at night? _____

On the average, how many times do you wake up during the night? _____

-If you do wake up, what typically causes it?

Do you feel well-rested when you wake up in the morning? Yes / No

-If no, what are thoughts about why?

Have you been diagnosed with a sleep disorder? Yes / No If yes, what type _____

On a scale from 1 to 10 with 10 being extremely stressed and 1 not stressed at all, where would you place yourself? _____

What do you do to relax?

Do you participate in any spiritual practices? If so, what?

When was the last time you went to get medical help? _____ What for? _____

How often do you typically receive medical help? _____

Are you able to get the medical care you need? Yes / No _____

-If no, why not?

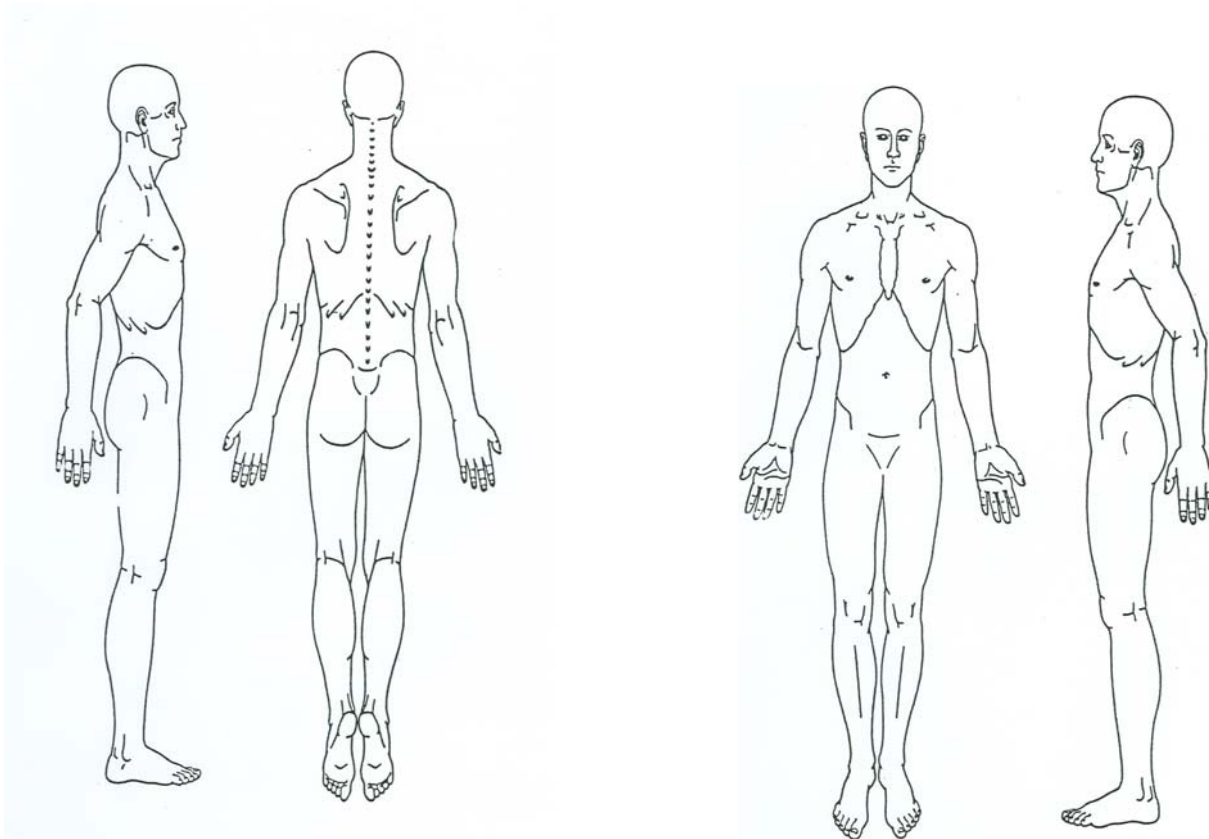
Do you get regular preventive screenings? Like breast exams, blood pressure checks, pap smears, colonoscopies, prostate exam, etc. -please list which one(s), and how often:

Which of the following have you ever consulted? What is your comfort level with each type of provider?

Type of Provider (Check all consulted previously)	Comfort level with receiving care/treatment (1 not comfortable, 5 very comfortable; please circle)	Any other thoughts/concerns about providers? (OPTIONAL: Use space below as needed)
1) <input type="checkbox"/> Medical physician	1) 1 - 2 - 3 - 4 - 5	1)
2) <input type="checkbox"/> Nurse practitioner	2) 1 - 2 - 3 - 4 - 5	2)
3) <input type="checkbox"/> Psychologist	3) 1 - 2 - 3 - 4 - 5	3)
4) <input type="checkbox"/> Acupuncturist	4) 1 - 2 - 3 - 4 - 5	4)
5) <input type="checkbox"/> Oriental medicine practitioner	5) 1 - 2 - 3 - 4 - 5	5)
6) <input type="checkbox"/> Chiropractor	6) 1 - 2 - 3 - 4 - 5	6)
7) <input type="checkbox"/> Massage therapist	7) 1 - 2 - 3 - 4 - 5	7)
8) <input type="checkbox"/> Other: _____	8) 1 - 2 - 3 - 4 - 5	8)

Name: _____ Today's date: _____

Please mark on the body forms with an "X" where you are experiencing any tension, stiffness or other discomfort. Please describe the sensation (burning, stinging, aching, pins-n-needles, etc.): _____



Please answer the following to the best of your knowledge.

Are you troubled by any of the following?

General

- Extreme tiredness
- Unexplained weight loss
- Extreme Thirst
- Lumps or swelling

Where? _____

Eyes, ears, nose, and throat

- Loss of hearing
- Ringing in ears
- Disturbances in vision
- Repeated nose bleed
- Nasal stuffiness or drainage
- Severe Dental Problems
- Hoarseness or voice change
- Trouble swallowing

Skin and Hair

- Repeated skin rash
- Repeated sores
- Moles that have changed

WOMEN

of pregnancies? _____

Nervous System

- Frequent or severe headaches
- Staggering or loss of balance
- Unexplained dizziness
- Fainting (blackout)
- Head injury
- Twitching or tremors (shakiness)
- Numbness or tingling: hands or feet
- Stress or nervousness
- Feeling depressed
- Thoughts of suicide
- Trouble concentrating or remembering

Genitourinary System

- Difficult or painful urination
- Urination more than once a night
- Trouble holding urine
- Bladder or kidney infection
- Blood in your urine
- History of kidney stone
- Problem with sex function
- Sores or discharge
- Problems having children
- Sexually active
- Strong or weak urine flow

Heart, Lungs and circulation

- Chronic cough
- Coughing up blood
- Abnormal chest X-ray
- Wheezing
- Chest Pain
- Shortness of breath
- Palpitations or irregular heartbeat
- Heart murmur
- Leg cramps while walking
- Ankle swelling

Psychosocial Health

- Fearful
- Violence towards self or others
- Thought disturbances
- Panic and/or anxiety
- Hearing voices/seeing things
- Spirituality issues
- Need for social services
- Irregular sleep patterns or sleep disturbance
- Alcohol and/or chemical issues
- Smoking or chewing

Digestive System

- Poor appetite
- Heartburn
- Repeated abdominal pain
- Tarry (black) stool
- Frequent nausea/vomiting
- Bowel movement changes
- Frequent diarrhea
- Constipation
- Rectal bleeding

Skeleton and joints

- Swollen or painful joints
- Gout
- Back trouble
- Difficulty walking
- Bursitis or tendonitis

Patient Signature _____ Date _____

Any other information you would like to provide? *****PLEASE USE REVERSE SIDE*****

Name: _____ Sex _____ Age _____ Today's Date: _____

PATIENT NOTE: PLEASE STOP HERE. THIS SECTION TO BE FILLED IN BY ATTENDING PRACTITIONER(S)

Chief complaint:

History of presenting complaint:

Review of systems:

Past medical history:

Family medical history:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Scizophrenia |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Borderline Personality Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Blood Clotting Disorders | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Other Psychological Disorders |

Other Information: _____

Social and personal history:

Other relevant history:

INTEGRATED CARE UNIT STUDENTS PROVING INTAKE HISTORY:

Name: _____ Signature: _____ Profession: _____

Name: _____ Signature: _____ Profession: _____

Name: _____ Signature: _____ Profession: _____

Integrated care faculty supervisors:

Name: _____ Signature: _____ Profession: _____