GLADDMD
INTEGRATIVE MEDICINE

Client Intake Form

The practice of Integrative Medicine requires the understanding of clients as a whole: Mind, body and spirit. 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 ☐ Other: _____

Primary Care Physician: _____

Goals:

Please list the reasons you have come to GladdMD 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

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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
- ☐ Lightheaded/dizzy
- ☐ Convulsions
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Head injury
- ☐ Problems staying asleep
- ☐ Snore
- ☐ Restless legs

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

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: _____ Catheterization: _____
- ☐ Spinal Fusion: _____
- ☐ Joint Replacement: _____
  Which joint: _____
- ☐ Other: _____

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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 _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Disease _____
- ☐ Stroke _____
- ☐ Member/Type: _____
- ☐ Member/Type: _____
- ☐ Member/Type: _____

Allergies:

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

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:

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Social History (cont'd):

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

Tobacco: ☐ Yes ☐ No 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 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 then 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/day	Why you take it

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Stress:

Stress and the management of stress if 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 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:_____
- ☐ Cups of decaf coffee: _____
- ☐ Cups of regular tea: _____
- ☐ Cups of decaf tea:_____
- ☐ Regular soda: _____
- ☐ Diet soda: _____
- ☐ Crystal Light: _____
- ☐ Artificial Sweetener packs (Splenda or others): _____
- ☐ Flavored water or Propel: _____
- ☐ Meals per day: _____
- ☐ Meals made at home: _____

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Client Two Day Food Diary

The Center for Integrative Medicine believes very strongly that the food you put in your body plays a large role in your health; both positively and negatively. A food diary is a very valuable resource for determining your current level of nutrition. It will allow us to make recommendations for improvement, as well as consider the possibility of some groups of foods that may be causing symptoms.

Please choose two days to record all of your intake. These days should be considered "normal", don't choose days where your foods are drastically different from usual. Try to record intake for at least one weekday and one weekend day, because food choices can be different. This is preferred but not necessary.

Meal	Day 1	Day 2
Breakfast		
Lunch		
Dinner		
Snacks		
Beverages (soda, coffee, etc.)		