NorthShore University HealthSystem

Medical Group

Integrative Medicine Intake Form

Please bring this completed form and a copy of your medical records to your appointment
OR FAX 847-657-3521

Name	Age	Appointment date	Birth date

Contact # _____ Email _____

Concern (Please rank by priority) *Example: Headaches*	Onset *Example: June 2000*	Frequency *Example: 4x/week*	Severity *Example: 5 out of 10 or mild/mod/severe*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How were you referred to our center?

What are your goals for this visit?

Your Past Medical History- include date or year of diagnosis. You may also attach a separate list.
Example: Reflux/heartburn - started 2003; had scope procedure 8/05 w/ normal result; ***please be succinct***

1. _____
2. _____
3. _____
4. _____
5. _____

Family Medical History (indicate type of disease)	**Family Medical History**
Mother: _____	_____
Father: _____	_____
_____	_____

Surgery (major/minor procedures), when, where	**Injuries** *Example: Car accident 1995- head injury*

Tobacco ○ None ○ Smoked cigarettes from age _____ to _____. ____ packs per day
Check if you've used the following: ○ Cigars ○ Chewing tobacco

Alcohol ○ None ○ Estimated drinks per week _____ Preferred drink _____

Other drugs ○ None ○ Type(s) and frequency _____

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Allergic reaction/intolerances to medications *Example: penicillin-hives*	**Allergic reaction/intolerances (foods, environment)** *Example: cow's milk-bloating*

Medications (prescription & over the counter) *or attach your own list*	Dosage & frequency	Reason	Taking for how long?	Cost/month

Herbs & supplements *or attach your own list Please include brand name*	Dosage & frequency	Reason	Taking for how long?	Cost/month

Occupation _____

With whom do you live? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

What physical activities do you participate in & how often? _____

What do you do to relax? _____

Describe your sleep: include # hours/night _____

What are the major stressors in your life? _____
_____

Religious affiliation, past & present _____

What prior experiences have you had with alternative medicine? _____
_____
_____

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Nutrition History

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

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

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

How much water do you drink on a typical day? _____
Example: Four 16 ounce bottles water/day

How much caffeinated coffee and/or soda do you drink a day? **Coffee** _____ **Soda** _____

What kind of tea do you drink (green/white/oolong/black/herbal)? _____
_____
 # cups of tea per day _____

What type of oils or spreads do you add to your food? _____
_____

How often do you eat out at restaurants or fast food places per week? _____

Which restaurants do you typically visit? _____
_____

Please indicate the number of protein servings you consume during an average week:

Protein	**# servings** *(1 serving meat = 3 ounces cooked meat, poultry or fish = a deck of cards*
Red meat (beef, pork, lamb, veal, etc.)	
Fish/seafood	
Poultry	
Beans	
Soy (tofu, tempeh)	
Other sources(i.e. protein supplements)	