



CURRENT PRACTICES in INTEGRATIVE MEDICINE

*Example Intake
and Assessment Forms*

Integrative medicine is changing the way medicine is practiced in America. However, no two integrative medicine clinics or programs are identical. While many share patient populations, philosophies of care and treatment protocols, clinics and programs across the US utilize different approaches and economics, and often offer different services aimed at market segments unique to their locale and mission.

The Bravewell Current Practices in Integrative Medicine project documents and disseminates the many ways that integrative medicine is emerging within our health care system. All Current Practices presented are evidenced-based and have been vetted by a committee of experts.

Released in 2007, *Best Practices in Integrative Medicine: A Report from the Bravewell Clinical Network* outlined the current practices of seven leading integrative medicine clinics in the US. From core business models to strategies for growth to key services provided and effective marketing programs, *Best Practices in Integrative Medicine* presented how each of these clinics have achieved growing success within their own unique marketplace and corporate structure.

In this special Current Practices in Integrative Medicine Report, Bravewell presents a portion of the *Best Practices in Integrative Medicine: A Report from the Bravewell Clinical Network* for a focused examination of each of the highlighted clinical centers. All seven clinical center model studies can be downloaded at www.bravewell.org.

Starting in 2010, Bravewell began updating the Best Practices report. Current information can be found at www.bravewell.org.

The intake and assessment forms included in this report were provided by the members of the Bravewell Clinical Network. Please contact the appropriate center for permission to duplicate this material.

University of Maryland Integrative Medicine Intake Form

Name
MRN
Date

What are your goals for this visit? _____

Prioritize your most important health concerns today?

	<u>Concern</u> Ex: Headache	<u>Onset</u> June 1978	<u>Frequency</u> 4 times/wk	<u>Severity</u> mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

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

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

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

What are the major stressors in your life?

What do you do to relax/relieve stress? What interests/hobbies do you have? _____

Occupation (Current) _____
(Past) _____

Spiritual beliefs/religious affiliations, past, and present _____

Source of comfort and connection _____

HEALTH HABITS

What physical activity do you participate in, and how often? _____

Energy level _____

Describe your sleep pattern _____

Nutrition

How many meals do you generally eat per day? _____ Do you skip meals? _____

How many servings of fruit per day? (Sv: 1 small fruit, ½ C canned/chopped fruit, ¼ C dried fruit) _____

How many servings of vegetables do you consume each day? (Sv: ½ C raw/cooked, 1 C leafy veg.) _____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? _____

What are your sources of protein? _____

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

What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda, etc.) _____

How would you describe your relationship with food? _____

How often do you eat out? _____ Who prepares the meals at home? _____

	Amount Per Day	Amount Per Week	Never Used
<u>Tobacco</u>			
Cigarettes	_____	_____	_____
Cigars/Pipe	_____	_____	_____
Chewing	_____	_____	_____

Recreational Drugs

<u>Alcohol</u>	_____	_____	_____
	_____	_____	_____

Have you ever had to cut down on your drinking? ____ Yes ____ No
 Do you get annoyed when someone asks about your drinking? ____ Yes ____ No
 Do you ever feel guilty about your drinking? ____ Yes ____ No
 Do you ever make excuses for drinking or for your behavior while drinking? ____ Yes ____ No

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you and circle the appropriate choice when given.

- | | |
|--|--|
| _____ Alcoholism or Substance Abuse | _____ Lung Disease (Asthma, COPD, etc.) |
| _____ Anemia (Sickle Cell or Other) | _____ Mental Trouble/ Depression/Anxiety, etc. |
| _____ Arthritis/Joint Disease | _____ Pneumonia |
| _____ Blood Clots/Phlebitis | _____ Radiation Treatments |
| _____ Cancer (Specify Type: _____) | _____ Rheumatic Fever |
| _____ Diabetes | _____ Seizures, Epilepsy |
| _____ Digestive (Ulcerative Colitis, Crohns, etc.) | _____ Serious Injury or Accident
(Type _____) |
| _____ Easy Bleeding | _____ Sexually Transmitted Disease
(Chlamydia, Warts, Herpes) |
| _____ Frequent Sinusitis | _____ (Specify Other _____) |
| _____ Gall Bladder Trouble | _____ Skin Disease |
| _____ Hay Fever, Allergy, Eczema | _____ Stroke |
| _____ Hearing Loss | _____ Thyroid Disease |
| _____ Heart Attack, Heart Disease, Heart Failure | _____ Tuberculosis (TB) |
| _____ Heart Murmur | _____ Urinary Difficulties
(Incontinence, Infections, etc.) |
| _____ Headaches (Migraines, etc.) | _____ Vision Problems |
| _____ High Blood Pressure | _____ Other (Specify) _____ |
| _____ High Cholesterol | _____ Other (Specify) _____ |
| _____ History of Infertility | _____ Other (Specify) _____ |
| _____ Kidney Infection/ Stones | |
| _____ Liver Disease, Hepatitis, etc. | |

Please list any operations/surgical procedures/blood transfusions/major injuries (with dates):

Immunizations/vaccinations:

WOMEN ONLY

Reproductive History

Age at 1st menstrual period _____ First day of most recent menstrual period _____
 Usual Flow: ____ Heavy ____ Moderate ____ Light Length of period in days _____
 Number of days between periods _____
 Do you have (please circle): Painful Periods, Missed Periods, Spotting Between Periods,
 Vaginal Bleeding, Unusual Discharge/Infection, Recurring Vaginal Infections
 If you have gone through menopause, have you had any post-menopausal bleeding? _____
 Date of last Pap _____ History of abnormal Paps? _____
 Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/other problems? _____

Jefferson-Myrna Brind Center of Integrative Medicine

Thomas Jefferson University Hospital
111 South 11th Street; Suite 6215; Philadelphia, PA 19107
Fax: (215) 955-2509; Tel: (215) 955-2221

Patient Intake Form (v.6/2/03)

Name	<u>Date of Birth</u>	<i>Appointment Date</i>
-------------	-----------------------------	--------------------------------

<i>Home phone:</i>	<i>Work phone:</i>	<i>Cell phone:</i>
---------------------------	---------------------------	---------------------------

Who referred you or how did you hear about us? What physician referred you to us?

What health problems would you like us to address on your initial visit? Please rank by priority:

1. _____
2. _____
3. _____

What other major health problems or illnesses do you have or did you have in the past?

	Past	Present		Past	Present
Arthritis			Thyroid disease:		
Asthma			Other:		
Cancer					
Diabetes					
Digestive disease					
Fibromyalgia					
Heart Disease					
Hepatitis					
Hypertension					

List all vitamins, minerals, herbs and other nutritional supplements. When possible, indicate the mg or I.U.'s and the form (e.g. calcium carbonate vs. calcium lactate). You may bring in a photocopy of container labels.

Supplement	When Started	Daily Dosage	Supplement	When Started	Daily Dosage

Family Medical History:

	List family members who have or had this illness.
Arthritis	
Alcoholism	
Cancer: Breast	
Cancer: Colon	
Cancer: Prostate	
Cancer: Other	
Depression or Bipolar Disorder	
Diabetes	
Heart disease	
High blood pressure	
Other:	
Other:	
Other:	

Diet

List any food sensitivities or intolerances:

Are you on any special diet? What foods do you avoid? Why?

Substance Use

Cigarettes Never Used Smoked from age _____ to _____, _____ packs per day.

Other Tobacco Never Used Cigars Pipes Snuff Chewing Tobacco
Used from age _____ to _____, _____ times per day.

Alcohol Never Used Estimate drinks per week:
 Alcohol problem from age _____ to _____

Use of other recreational drugs?

Relationships

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

What pets do you live with?

Do you feel safe in your home?

Are you, or were you, married or partnered?

What are the ages of your children?

Who are the most important people in your life?

Occupation

What education have you completed?

What are your current studies?

What is your current or previous work?

What are your volunteer activities?

Wellness Practices

What exercise do you do? How often?

What mind-body practice do you have (e.g. meditation, yoga, prayer)? How often do you do this practice?

What wellness therapies do you receive on a routine basis?

Acupuncture	<input type="checkbox"/>	Psychotherapy	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	Other:	
Energy work	<input type="checkbox"/>		
Massage	<input type="checkbox"/>		

What are your leisure activities / hobbies?

Review of Systems

Do you have any of the following symptoms or problems?

General	
Fatigue	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>
Eyes	
Blurry vision	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>
Ears / Nose / Throat / Sinuses	
Hearing loss	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>
Pain	<input type="checkbox"/>
Frequent canker sores	<input type="checkbox"/>
Heart / Circulation	
Palpitations or irregular pulse	<input type="checkbox"/>
Chest discomfort (tightness / pressure / pain)	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>
Lungs	
Shortness of breath	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Digestion / Elimination	
Heartburn	<input type="checkbox"/>
Nausea / Vomiting	<input type="checkbox"/>
Abdominal pain / cramps	<input type="checkbox"/>
Abdominal bloating	<input type="checkbox"/>
Excessive belching	<input type="checkbox"/>
Excessive flatus	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>
Bladder / Kidneys / Urination	
Frequent infections	<input type="checkbox"/>
Urgency	<input type="checkbox"/>
Difficulty urinating	<input type="checkbox"/>
Pain with urination	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>
Leakage	<input type="checkbox"/>

Gynecological	
Abnormal periods	<input type="checkbox"/>
Severe premenstrual symptoms	<input type="checkbox"/>
Date of last menstrual period:	
Muscles / Bones / Joints	
Muscle pain	<input type="checkbox"/>
Muscle cramps or spasms	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>
Joint pain / stiffness / swelling	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Nervous system	
Headaches	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Balance problems	<input type="checkbox"/>
Weakness / numbness / tingling sensations	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>
Concentration problems	<input type="checkbox"/>
Allergies / Immune System	
Seasonal or other allergies	<input type="checkbox"/>
Hormonal / Endocrine	
Excessive thirst	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>
Cold or heat intolerance	<input type="checkbox"/>
Blood	
Easy bruising	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>
Skin	
Rashes	<input type="checkbox"/>
Eczema	<input type="checkbox"/>
Other	<input type="checkbox"/>
Psychiatric / Psychological	
Anxiety	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>

Challenges and Stressors

What major life decisions or changes are you facing?

What are the most significant stressors in your life right now?

Spirituality

Do you have a spiritual practice? What is it?

Do you actively practice any religion?

What brings meaning or purpose to your life?

What other information about you do you want your doctor to know?

[Empty text box for providing additional information for the doctor]

Thank you!

“The natural healing force within each of us is the greatest force in getting well.”
Hippocrates