INTEGRATIVE MEDICINE BEST PRACTICES

Example Intake and Assessment Forms

A Bravewell Collaborative Best Practices Report © 2007

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 Best Practices project documents and disseminates the many ways that integrative medicine is emerging within our health care system. All Best 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 best 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 Bravewell Best Practices 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 Best Practices 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?

	Concern	Onset	Frequency	Severity
	Ex: Headache	June 1978	4 times/wk	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? (Svg: 1 small fruit, ½ C canned/chopped fruit, ¼ C dried fruit) _______

How many servings of vegetables do you consume each day? (Svg: 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
Tobacco			
Cigarettes	_____________	______________	_________
Cigars/Pipe	_____________	______________	_________
Chewing	_____________	______________	_________
Recreational Drugs	_____________	______________	_________
Alcohol	_____________	______________	_________

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

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? _________________
____

<u>Contraceptive History</u>

Please circle the method of contraception you are currently using

Birth Control Pills Type ________________________ Total Years of Use _____
Diaphragm/Cap Type ________________________ Size___________________
IUD Type ________________________ Date of Last Change ___________
Norplant, Condom and/or Foam, Suppository Tubal Ligation
Hysterectomy Partner with Vasectomy None
Other ____
Problems with current method ____
____

Sexual Preference:

_____Heterosexual _____ Homosexual _____ Bisexual

MEN ONLY

Do you have: ____ Prostate Problems _____ Testicular Cancer
____ Vasectomy _____ Sexual Dysfunction

Sexual Preference:

_____Heterosexual _____ Homosexual _____ Bisexual

MEDICATIONS

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	Reason	When Started	Dosage Per Day	Cost
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______
________________	_____________________	__________	____________	_______

Are you allergic to or have you had a "bad reaction" to any medications or other substances?
____ No ____ Yes

If yes, please specify drug(s) and type of reaction: ____
____
____

What vitamins/mineral/herbal supplements are you taking now?

Brand or Other name (manufacturer)	Reason	When Started	Dosage Per Day	Cost
Example: St. John's Wort (Nature's Way)	*Feeling down*	*2 months ago*	*300 mg/day*	*$15/30*

____

____

____

____

____

____

____

____

____

____

____

FAMILY MEDICAL HISTORY

Who in your immediate family has any of the following? Place appropriate letter in blank.
(F=father, M=mother, S=sibling, G=grandparent)

_______ Alcoholism or Substance Abuse
_______ Anemia (Sickle Cell or Other)
_______ Arthritis
_______ Cancer (Specify Type _______________)
____
_______ Diabetes
_______ Digestive (Ulcerative Colitis, Crohns, etc.)
_______ Easy Bleeding
_______ Glaucoma
_______ High Blood Pressure
_______ Hay Fever, Allergy, Eczema
_______ Headaches (Migraine, etc.)
_______ Heart Attack, Heart Disease, Heart Failure
_______ High Cholesterol
_______ Kidney Disease
_______ Liver Disease (Hepatitis, etc.)
_______ Lung Disease (Asthma, COPD, etc.)
_______ Mental Trouble/ Depression/ Anxiety
_______ Seizure, Epilepsy
_______ Stroke
_______ Suicide
_______ Thyroid Disease
_______ Tuberculosis (TB)
_______ Ulcers
_______ Other
_______ Other

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

Name	Date of Birth	*Appointment Date*

Home phone: *Work phone:* *Cell phone:*

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					

What major operations have you had?

Tonsillectomy Year:	Appendectomy Year:	Sinus surgery Year:
Other—Please note year of procedure:		

Allergies (medication and all other):

What medications are you taking? (Include over-the-counter-drugs)

Medicine	When Started	Daily Dosage	Medicine	When Started	Daily Dosage

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 Alcohol problem from age _______ to _______	Estimate drinks per week:
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 Chiropractic Energy work Massage Psychotherapy Other:
What are your leisure activities / hobbies?

Review of Systems

Do you have any of the following symptoms or problems?

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

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

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?

Thank you!

"The natural healing force within each of us is the greatest force in getting well."

Hippocrates