Please be certain that all intake forms are completed and brought with you to your appointment at **Chapman Integrative Health PLLC (CIH).** This information will be scanned into your electronic medical record.

Personal Health History & Self Reflection Inventory

Name: _____ **Date:** _____

Medical Record #: _____ **Date of Birth**_____ **Age** _____

What is the best contact phone #_____ May we leave a message at this number? Yes No
Preferred Pharmacy (Name, location, phone #): _____

Primary Care Provider (CIH is consultative only)? _____

Please list all physicians that you see. (Please include Mental Health Professionals)

Name	Address	Specialty, or condition that is being treated

Please list any complementary and/or alternative practitioners you see or have seen in the past (i.e., chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).

Approximate Date(s) of Treatment	Name of Therapist or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for Treatment	Beneficial Experience?

What health issues do you want to focus on during this visit?

Current Medical Problems (e.g. diabetes, heart disease, hypertension, etc.):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical History: List any major past illnesses, hospitalizations (include year or date if known).

	Date		Date

Past Surgical History: List any past surgeries (and what year/date).

	Date		Date

Past Gyn/Obstetrical History: List any past pregnancies.

Vaginal Births		Miscarriage/ Still births	
Caesarian Sections		Pregnancy Terminations	
Abnormal PAP tests		Other GYN Procedures	

Family History: Have your close relatives (parent, brother or sister, child, grandparent) had the following?

	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High Cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other Cancer--what type?				
Kidney Disease				
Osteoporosis				

Rheumatoid Arthritis				
Asthma				
Mental Health disorder				
Substance Abuse				

Pharmaceuticals and Supplements:

Do you have Medication allergies? o Yes o No If yes, please list:

Medication	Reaction	Medication	Reaction

Please list all prescribed and over-the-counter medications you take regularly. ***Please include all supplements, vitamins or herbal products.***

Medicine/ Supplement including Dose	Frequency	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please outline your use of the following, past or present:

Product:	Current Use? Yes/No	Quantity Per Day	Quantity Per Week	Past Use? Yes/No	Do others have concern about your usage?
Tobacco					
Alcohol					
Recreational Drugs					
Caffeine:					

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? ❑ Yes ❑ No

	Date		Date
Pap/pelvic exam (females)		Tetanus vaccine (specify Td or Tdap)	
Mammogram (females)		Flu vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood (Stool Guaiac)		Zoster (shingles) vaccine	
Rectal prostate exam (males)		Hepatitis A	
Prostate Specific Antigen (males)		Hepatitis B	
Bone Density (Dexa)		MMR	
Eye exam		Gardesil (HPV vaccine)	
Cardiovascular stress test		Other	

Review of Symptoms: Please check no or yes for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		**GASTROINTESTINAL**	Yes	No
Fever				Diarrhea/Constipation		
Sweats at night				Indigestion/heartburn		
Hot flashes				Nausea		
Temperature intolerance				Blood in stool		
Excessive thirst				**GENITOURINARY**		
Fatigue				Pain or burning on urination		
Sleep difficulties				Frequent urination		
Daytime sleepiness				Waking to urinate more than once at night		
Unplanned weight change				Excessive urination		
SKIN				Difficulty emptying bladder		
Rash				Urinary incontinence		
New or changing moles				Decreased sexual desire		
EYES				Pain with intercourse		
Pain				Sexually Transmitted Diseases		
Redness				Fertility issues		
Vision change				**Men:**		
EAR, NOSE, THROAT				Erectile dysfunction		
Hearing loss				**Women:**		
Ringing in ears				Heavy vaginal discharge		
Dizziness or vertigo				Heavy menstrual bleeding		
Bleeding gums				Painful menstrual periods		
Nosebleeds				Irregular menstrual bleeding		
BREAST				**MUSCULOSKELETAL**		
Breast Pain				Generalized or all-over pain		

Masses and or Lumps				Joint pain		
Nipple discharge				Stiffness		
Skin changes				Joint swelling		
CARDIOVASCULAR				Joint redness		
Chest pain				Back or neck pain		
Heart murmur				**NEUROLOGICAL**		
Irregular heart beat (palpitations)				Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema				Headache severe and/or frequent		
PULMONARY				Seizures		
Wheezing or shortness of breath				Muscle weakness, TIA or stroke		
Chronic cough				Fainting or loss of consciousness		
HEMATOPOIETIC				Localized numbness, tingling, neuropathy		
Swollen lymph glands				**PSYCHOLOGICAL**		
Blood clots				Anxiety		
Excessive bleeding				Depression		
Anemia				Memory loss		
				Mood swings		

Trauma History: Have you ever been the victim of trauma or abuse (including sexual, emotional, physical abuse or neglect and/or being a victim of an accident, violent crime, or a natural disaster)? o Yes o No

If yes, is this an active issue in your life that you would like to address while you are here? o Yes o No

_____

_____

Movement, Exercise and Rest:

What forms of exercise and movement do you enjoy?

_____

Please describe your usual physical activity

Activity	How often	How long each time

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

Describe any issues you have with sleep. _____

_____

Nutrition: Please list any food allergies or sensitivities:

Foods	Reaction	Foods	Reaction

Please list everything you ate in the last 24 hours.

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? ❑ Yes ❑ No If yes, please describe:

_____

Are you comfortable with your relationship with food? ❑ Yes ❑ No
Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No
Who prepares your meals? _____

Personal and Professional Development:

Current or past occupation: _____
❑ Retired? ❑ Working at home? ❑ Care-taking? ❑ Disabled? ❑Unemployed?

Are you happy with your occupation? _ o Yes o No
Why? _____
_____
Do you anticipate any work changes in the near future? Retirement, etc. _____
_____
Do you have a Racial/Culture heritage that is important to you? _____
_____

Relationships:
Relationship status: _____ if married or partnered, what is your relationship length? _____
What are your living arrangements? _____ Number of children and ages: _____
Are you sexually active? ❑ Yes ❑ No are you happy with your sexual life? _____
Which relationship(s) fulfill and/or empower you? _____
Who or what drains your energy?
_____

Physical Environment: Do you have specific health concerns about your current home or environment (Quality of air, water, etc.)?

_____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

_____

Spirituality:

What things or activities bring you your greatest joy and meaning? What inspires you?

_____

_____

What things create the greatest challenges for you? _____

_____

What makes you feel connected to the larger world? -Describe your spiritual or religious practices if any (i.e., meditation, prayer, time in nature, worship attendance, etc.)._____

_____

If time and money were not an issue, describe the things you long to do in your life._____

_____

_____

Mind-Body Connection:

Rate the amount of stress in your life: □ None □ A Little Bit □ Moderate □ Quite a Lot □ Extreme How well do you manage stress? □ Not at All □ A Little Bit □ Moderate □ Quite well □ Excellent

What are the main sources of stress in life? (Personal, professional, financial etc.) _____

_____

What are your methods of coping with the stress in your life? _____

_____

What are your health goals? What are your overall goals for improving your health and your life? ___

_____

_____

_____

_____

Is there anything else that would be helpful for us to know about you? _____

_____

_____