COMPLETE THIS FORM IF YOU ARE A NEW PATIENT SCHEDULED TO SEE ONE OF OUR INTEGRATIVE MEDICAL DOCTORS (MDs)

Name: MR #:

YANG INSTITUTE
OF INTEGRATIVE MEDICINE

PATIENT MEDICAL INTAKE QUESTIONNAIRE

The ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your responding thoughtfully and accurately to both these written questions and those posed during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance efficiency and will provide for more effective use of your scheduled consultation time. The answers to these questions will help me identify underlying causes of illness and will also assist in formulating a treatment plan.

Please send or bring copies of relevant imaging reports (X-rays, CT, MRI, etc), and recent blood work and test results and anything else you think is useful.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____

Work Phone: (_____) _____-_____ Ht. _____'_____" Wt. _____

Cell Phone: (_____) _____-_____ Email: _____

May we have your permission to email information about topics that may interest you? Yes____ No____

How did you hear about this office? _____

Emergency Contact (name and phone #): _____

Pharmacy Phone: _____ Today's Date: _____

Do you have an advanced directive (circle one)? Yes No, I need information

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Describe your primary health and wellness goals:

1._____

2._____

3._____

Note: Please provide all reports, letters, lab work, etc. that can help to evaluate and treat the problems listed below.

Describe your most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your second most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your third most important problem (include diagnosis date if appropriate):	
What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

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Do you have any allergies – food and/ or medications (circle one)? **Yes** **No**
If yes, list and describe:

What medications (***not supplements***) are you taking now? Include non-prescription / OTC drugs.

Medication Name/Strength	AM/Noon/PM	Date Started	Medication Name / Strength	AM/Noon/PM	Date Started

List all vitamins, minerals, and other nutritional supplements you are taking now. Indicate whether mg or IU (i.e. the quantity) and the form (i.e., calcium carbonate vs. calcium lactate). If you need more space please list in a separate sheet. You may bring a photocopy of the supplement container labels.

Vitamin/Mineral/ Supplement Name/Strength	AM/Noon/PM	Date Started	Vitamin/Mineral/ Supplement Name/Strength	AM/Noon/PM	Date Started

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Other Medical and Surgical History (check and indicate date of diagnosis for each):

√	ILLNESS	DATE	√	ILLNESS	DATE
	Anemia			Hepatitis	
	Arthritis			High blood fats (cholesterol, triglycerides)	
	Asthma			High blood pressure (hypertension)	
	Bronchitis			Irritable bowel syndrome	
	Cancers			Kidney stones	
	Chronic Fatigue Syndrome			Mononucleosis	
	Crohn's Disease or Ulcerative Colitis			Osteopenia / Osteoporosis	
	Depression, Anxiety or Bipolar Disorder: Describe			Pneumonia	
	Diabetes			Rheumatic fever	
	Emphysema			Rheumatoid Arthritis	
	Epilepsy, convulsions, seizures			Sinusitis	
	GERD/ Ulcers			Sleep apnea	
	Gallstones			Stroke and/ or TIAs	
	Gout			Thyroid disease	
	Heart problems: Describe			Other: Describe	
Comments:					

INJURY (back, head, neck, broken bone, sprain, tear, concussion, or other)	**DATE**	**DESCRIPTION** (e.g., fall, accident, or other physical trauma)
OPERATIONS/HOSPITALIZATIONS (Include dental procedures)	**DATE**	**COMMENTS/DESCRIPTION**

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DIAGNOSTIC STUDIES: List studies completed within the past two years. Provide copies if available.

DIAGNOSTIC STUDY	DATE	RESULTS	DIAGNOSTIC STUDY	DATE	RESULTS
Latest blood work			CAT Scan of (list all)		
Bone Scans (describe)			NMR/MRI of (list all)		
X-rays: describe			Upper GI Series		
Thermography			Lower GI: Describe		
Heart Tests: (describe)			Colonoscopy		
Pet Scan			DXA scan (bone density)		
Other (describe)			Other (describe)		
Comments:					

Vaccines:

Please list the dates of the most recent vaccines you have received (if you are unsure, list either the approximate date or write 'unsure'):

Vaccine	Date
Tetanus	
HHV	
Flu	
Pneumonia	
Shingles	
Other (describe)	

Family Medical History:

Illness	Family members who have or have had illness	Illness	Family members who have or have had illness
Arthritis		Diabetes	
Alcohol or Drug Abuse		Heart disease	
Cancer: Breast		High blood pressure	
Cancer: Colon		Other:	

Illness	Family members who have or have had illness	Illness	Family members who have or have had illness
Cancer: Prostate		Other:	
Cancer: Other		Other:	
Depression or Bipolar Disorder		Other:	

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? □Yes □No If yes, specify:

Wellness Practices:

What exercise do you do? How often? For how long?
What mind-body practice do you have (e.g. meditation, yoga, prayer)? How often?
What wellness therapies do you receive on a routine basis? □ Acupuncture □ Chiropractic □ Energy work □ Massage □ Other:
What are your leisure activities / hobbies?

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Challenges and Stressors / Emotional and Psychological Well-Being:

What are the top two sources of stress in your life?

How do you believe those sources of stress affect your daily life?

What major life decisions or changes are you facing?

Describe major losses experienced in the past 3 years:

Have you had emotional trauma (circle one)? **Yes** **No**
If yes, please describe:

Have you ever had physical trauma?

If yes, please describe:

Was your childhood happy or troubled?

If troubled, please describe:

Note: If you don't feel comfortable writing about this, please consider talking to the doctor at your appointment. Often unhappy childhood events may have an impact on how the body handles stress, injury or illness as an adult.

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Rate how well have things been going for you:

	Very Well	Good	Fair	Very Poor	Doesn't apply		Very Well	Good	Fair	Very Poor	Doesn't apply
In your job						With your attitude					
In your social Life						With your boyfriend/girlfriend					
With friends						With your children					
With sex						With your parents					
						With your spouse					

Psychotherapy/counseling (circle one): **Current** **Previous**
Dates: _____ **Type:** _____

Comments:
_____

Relationships:

With whom do you live? (include: roommates, friends, partner, spouse, children, parents, relatives) Pets?
Do you feel safe in your home (circle one)? **Yes** **No**
Are you married or partnered (circle one)? **Yes** **No**
If you have children, ages of children?
Who are the most important people in your life? What is the attitude of those close to you about your health issues (circle one)? **Supportive** **Somewhat supportive** **Not supportive**

Education / Occupation:

Level of education completed:_____ Employed (circle one): **Yes** **No** Current Occupation:_____ Describe volunteer activities: Amount of time lost from work or school due to illness in past year: □ 0-2 days □ 3-14 days □ > 15 days

Spirituality / Religion:

Do you have a spiritual or religious practice (circle one)? **Yes** **No** If yes, describe:
What brings meaning or purpose to your life?

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Review of Systems* Do you have any of the following symptoms or problems (check any that apply)?

General		Pain with urination	☐
Fatigue	☐	Blood in urine	☐
Difficulty sleeping	☐	Urinary leakage	☐
Eyes		**Muscles / Bones / Joints**	
Blurry vision	☐	Muscle pain	☐
Eye pain	☐	Muscle cramps or spasms	☐
Ears / Nose / Throat / Sinuses		Tendonitis	☐
Hearing loss	☐	Joint pain / stiffness / swelling	☐
Ringing in ears	☐	Low back pain	☐
Frequent infections	☐	**Nervous system**	
Pain	☐	Headaches	☐
Frequent canker sores	☐	Dizziness	☐
Heart / Circulation		Balance problems	☐
Palpitations or irregular pulse	☐	Weakness / numbness / tingling sensations	☐
Chest discomfort (tightness/pressure/pain)	☐	Memory problems	☐
Leg swelling	☐	Concentration problems	☐
Lungs		**Allergies / Immune System**	
Shortness of breath	☐	Seasonal or other allergies	☐
Wheezing	☐	**Hormonal / Endocrine**	
Digestion / Elimination		Excessive thirst	☐
Heartburn	☐	Excessive hunger	☐
Nausea / Vomiting	☐	Cold or heat intolerance	☐
Abdominal pain / cramps	☐	**Blood**	
Abdominal bloating	☐	Easy bruising	☐
Bladder / Kidneys / Urination		Abnormal bleeding	☐
Frequent infections	☐	**Skin**	
Urgency	☐	Rashes	☐
Difficulty urinating	☐	Eczema	☐

*Adapted with the permission of the Institute for Functional Medicine

Rate your overall level of energy between 0 and 100%? _____ Average # of hours of sleep?_____
Rate in general how rested you felt within the first hour upon awakening after an adequate amount of sleep during the past month (Use scale: 0 (not rested at all) - 10 (very rested) _____

BM frequency (circle one): > 3x / day 1-3x / day 4-6x / week 1-3x / week or fewer

Describe any noteworthy characteristics regarding BM consistency or color (e.g. loose, small/hard, green, etc):_____
_____

Intestinal gas (circle all that apply): Daily Occasionally Excessive Present with pain Foul smell

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For Women Only:

# of pregnancies: _____ Are you pregnant now (circle one)? **Yes** **No**
Are you breastfeeding now (circle one)? **Yes** **No**

# of term births _____ # of abortions _____ # of preemies _____ # of miscarriages _____

Birth weight of largest baby _____ Smallest baby _____

Toxemia - high blood pressure (circle one)? **Yes** **No**

Other problems with pregnancy _____ Age at first period _____

Date of Last Pap Smear _____ Results (circle one): **Normal** **Abnormal**

Date of Last Mammogram_____ Results (circle one): **Normal** **Abnormal**

Date of last period_____ Date of hysterectomy, if applicable: _____

Do you still have your ovaries (circle one)? **Yes** **No** Are you sexually active (circle one)? **Yes** **No**
If yes, do you use protection? _____

Can you achieve orgasm (circle one)? **Yes** **No**

Have you ever used birth control pills (circle one)? **Yes** **No**

If yes, currently, (circle one)? **Yes** **No** Does/did taking the pill agree with you (circle one)? **Yes** **No**

Do you currently use contraception (circle one)? **Yes** **No**
Type?_____

Are you in menopause (circle one)? Yes No If yes, age at last period_____

Do you experience (circle all that apply):

Hot flashes **Night Sweats** **Vaginal Dryness** **Emotional Upheavals**

Insomnia **Anxiety** **Low Sex Drive** **Mental Fog**

Tiredness **Difficulty keeping lean weight on** **Difficulty with workout results**

Do you take (circle all that apply):
Estrogen **Ogen** **Estrace** **Premarin** **Progesterone** **Provera**
Other:_____

Did you take HRT at one time (circle one)? **Yes** **No**
If yes, how long have you been or were you on HRT _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS) (circle one): **Yes** **No** **Not applicable**

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For Men Only (check all that apply):

Discharge from penis		Impotence	
Ejaculation problem		Lumps in testicles	
Genital pain		Poor libido (sex drive)	

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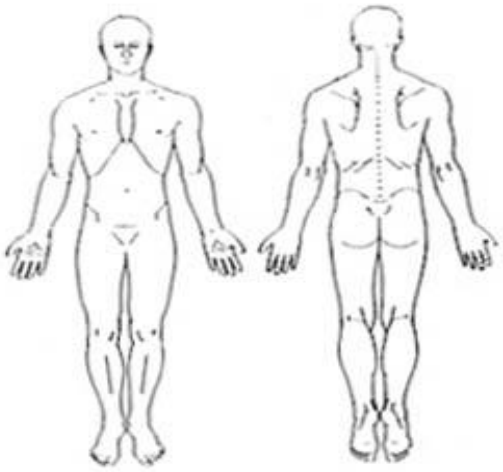
PAIN ASSESSMENT:
If one of your primary problems is pain, please fill out the following:

Do you have a problem with pain that adversely affects your ability to live your life (circle one)?
Yes No

Using the diagram, please circle the location(s) where you have experienced pain in the last month.



When did the pain start?

_____

Has the pain worsened (circle one)?
Yes No

If yes, when did the pain worsen?

_____

CONSTANT or INTERMITTENT (circle one)

Please circle two numbers to indicate the least and highest levels of pain you have experienced in the past month:

No pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please circle a number to indicate the average level of pain that you have experienced in the last month:

No Pain Worst pain imaginable
0 1 2 3 4 5 6 7 8 9 10

Please describe the quality of your pain(s), for example, burning, stabbing, achy, hopeless, electrical, tingling, pushing/ pressure, punishing and any other description that describes your experience.

_____

What makes your pain better, what makes it worse?

_____

_____

What have you tried to lessen the pain (circle all those that apply):

Acupuncture **Osteopathy** **Surgery** **Chiropractic** **Massage**

Movement Re-education (e.g. Feldenkrais) **Physical therapy** Other: _____

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Dietary Information: Place a check mark next to the food / drink that applies to your current diet. (check all that apply).

Usual Breakfast		**Usual Lunch**		**Usual Dinner**	
None/Miss		None/Miss		None/Miss	
Main Choices		Leftovers		Leftovers	
Eggs		Main Choices-Sandwiches		Main Choices – Protein	
Oatmeal / Hot cereal		BLT		Beans	
Cold cereal		Chicken/Turkey		Fish	
Any yogurt		Fish		Poultry	
Cheese		Lettuce/tomato/mayo		Meat	
Other Choices		Meat		Any cheese	
Bacon		Vegetable/cheese		Yogurt	
Bagel		Main Choices – Salads		Main Choices – Carbohydrates	
Coffee		Chef's salad		Rice	
Donut		Cesar salad		Potatoes	
Fruit		Mixed vegetable		Pasta	
Beverages		Salad dressing		Carrots	
Coffee		Any Yogurt or Cheese		Winter squash	
Tea		Beverages		Low Carb Vegetables	
Juice		Coffee		Greens	
Water		Soda		Yellow Vegetables	
Milk		Tea		Green beans	
Other: (List below)		Water		Beverages	
		Milk		Coffee	
		Dessert		Soda	
		Cookies		Tea	
		Fruit		Water	
		Other: (List below)		Milk	
				Dessert	
				Cookies	
				Fruit	
				Other: (List below)	

How many portions of the following do you consume each **week**?

Item	**Amount**	**Item**	**Amount**
Candy / Ice Cream		Slices of white bread (rolls/bagels)	
Cheese / Yogurt		Regular / diet sodas with / without caffeine	
Chocolate		Cups of decaffeinated tea / coffee	
Cups of coffee with caffeine		Cups of tea with caffeine	

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List typical snack foods eaten during day and evening:

_____

_____

Are you on a special diet (circle one)? **Yes** **No**
If yes, circle the diet type:
ovo-lacto **diabetic** **dairy restricted** **vegetarian** **vegan** **wheat restricted**
Other_____

Is there anything else about your diet that we should know (circle one)? **Yes** **No**
If yes, please explain:

_____

What diets have you followed in the past? Please describe your experiences (include positive and negative results)

_____

_____

_____

Do you cook (circle one)? **Yes** **No**
If yes, do you make enough food at dinner to have leftovers for another meal (circle one)? **Yes** **No**

What percentage of dinner meals do you eat at home? _____

Average # of times per week you eat at fast food restaurants (e.g. Burger King, McDonalds, etc.)? ____

	Yes	No	Sometimes	Comment
Do you get sugar cravings?				
Do you get carbohydrate cravings?				
Are you an emotional or comfort eater?				
Do you binge eat or eat without control either at a meal or when eating snacks?				

Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc. (circle one)? **Yes** **No**

Please describe if symptoms are associated with particular food or supplements: (Example: milk – gas & diarrhea).

_____

_____

Circle any of the following items that make you feel much worse when you eat or drink a lot of them:
high fat foods **high protein foods** **refined sugar (junk food)**
fried foods **high carb foods (bread, pasta, potatoes)**
Other_____

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Environmental Exposures (check all that apply):

√	**Item**	√	**Item**
	Regular exposure to second-hand smoke		Do you feel worse during: □spring □fall □summer □winter
	Mercury (silver) amalgam fillings How often do you eat tuna, swordfish or shark?_____		Exposure to toxic metals at home or work? □lead □cadmium □aluminum □arsenic □mercury
	Root canals? #_____		Reaction to flu shot? □Yes □No Describe _____
	# of cavities in last 2 years _____		Reaction to pneumonia (Pneumovax) shot ? □Yes □No Describe _____
	Bleeding gums		Travel outside US: When/Where
	Artificial joints or implants		Where did you grow up?
			Was there industrial pollution nearby?

Antibiotics / Oral Steroids (check all that apply)**:**

How often have you taken Antibiotics?	Fewer than 5 times	5 times or more	**How often have you taken oral steroids(Cortisone, Prednisone)**	Fewer than 5 times	5 times or more
Infancy/Childhood					
Teen Years					
Adulthood					

Genetic Testing:

Are you interested in any of these preventive tests for personalized genetic analysis of (please circle all that apply):

1. Cardiovascular System Health
2. Bone Health
3. Immune System Health
4. Detoxification Systems Make Up
5. Inflammatory Predisposition Make Up

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PATIENT CANCELLATION AND NO SHOW POLICY

In order to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner.

If you need to reschedule or cancel an appointment, we require a minimum of 24hrs notice. Pleases call the office at 866-437-3826.

“No shows” or last minute cancellations also leave empty appointment times, as well as other patients waiting to receive medical care. For that reason, clients that do not honor their appointments will be charged a cancellation fee as follows:

Cancellations & No Shows

- **If we are given less than 24-hour’s notice, there will be a $100 cancellation fee.**
- **You will be charged the *full session fee* if you are a no show for your scheduled appointment or cancel the day of your appointment**

We realize that on a rare occasion, emergencies may arise, and we will address these situations with you at that time.

We thank you for working with us to ensure services are provided to you in the best possible way.

Acknowledgement of Cancellation & No Show Policy

Name: _____

Signature: _____

Date: _____

Name: MR #:

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and to provide individuals with the Notice of our legal duties and privacy practices with respect to Protected Health Information.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

By signing this form you are also allowing our office to:

1. Confirm appointments by telephone. Please list the phone number that you prefer us to call: _____;
2. Disclose medical information requested by other treating physicians;
3. Leave messages or discuss medical information with your pharmacist;
4. Disclose medical information to your insurance company;
5. Request medical records and/or medical information when necessary from other physicians or health care facilities

I hereby give permission to disclose health information about me to the following people: (Please print name on the line provided)

Wife/Husband: _____
Daughter/Son: _____
Mother/Father: _____
Other: _____

In the event of a billing issue, do you give permission for us to discuss your bill with someone other than yourself? YES _____ NO_____

If yes, please list name(s)

_____

_____

If referred, please provide:
Doctor's name_____ Phone #_____

I have the right to withdraw or revise my permission at any time, in writing.

Print name: _____

Signature: _____ Date: _____