**INTEGRATIVE HEALTH CONSULTATION**

What are your primary goals for this visit?

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Please describe your prior experiences with Integrative Health:

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**A. TREATMENT TEAM**

Primary Care Provider (PCP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Lab: \_\_UCSF \_\_LabCorp \_\_ Quest

Please list all members of your care team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Integrative Clinical Services and Group Medical Visits**

Osher Center clinicians are trained in both biomedical and complementary medicine. To learn more about our practitioners and treatments, visit: <https://osher.ucsf.edu/patient-care/clinical-specialties>

**B. FOUNDATIONAL PRACTICES: Nourish, Move, Rest, Reflect**

Do you follow any specific diet or fast? \_\_\_Yes \_\_\_No *If yes, please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have concerns about your nutrition? \_\_\_Yes \_\_\_No *If yes, please describe*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you change your eating habits when you are upset, worried, or sad? \_\_\_Yes \_\_\_No

Do you eat when you are rushed? \_\_\_Yes \_\_\_No

**Please describe your typical diet**:

|  |  |  |
| --- | --- | --- |
|  | Time |  |
| Breakfast |  |  |
| Lunch |  |  |
| Dinner |  |  |
| Snacks |  |  |

**Approximately how many cups of the following fluids do you typically drink each day?**

|  |  |  |  |
| --- | --- | --- | --- |
| Water | Juice/Other  *Note type* | Caffeinated drinks  *Note type (coffee, tea, etc.)* | Soda  *Note type (diet, regular)* |
|  |  |  |  |

**Please describe your physical activity, exercise, or movement, and time spent per week:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Light Activity *(e.g., walking, stretching)* | Aerobic-Moderate *(i.e., light sweating)* | Aerobic-Vigorous/High  *(i.e., sweating, faster heart rate)* | Strengthening exercises *(e.g., yoga, weight training)* | Balance exercises |
|  |  |  |  |  |

**Please describe your sleeping patterns:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you interested in mind-body practices** (e.g., mindfulness, meditation, yoga )?\_\_\_Yes \_\_\_No

*If yes, please describe*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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To learn more about courses for mind-body wellbeing, visit: <https://osher.ucsf.edu/public-classes>

**C. MEDICATIONS AND SUPPLEMENTS: Prescription, Over-the-counter, Botanicals**

*Please list below. If a more convenient option, please feel free to attach a separate list or take photos.*

Name of Medication, Supplement, or Herb Dose or Strength How often do you take it?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you take cannabis or marijuana? \_\_\_Yes \_\_\_No *If yes, please describe the forms/effects on you:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. MIND-BODY HEALTH AND WELL-BEING**

**Do you experience physical or emotional pain?** \_\_\_Yes \_\_\_No *If yes, please answer the following:*

Circle a number from 0-10 that best describes how much pain you are having today:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain |

Where is the pain? What does the pain feel like?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes the pain worse? What makes the pain better?

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Please list any medications or supplements you take for pain relief:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please check or list any treatments you have tried for pain relief:

\_\_\_ Acupuncture \_\_\_ Physical Therapy \_\_\_ Injections (\*e.g., prolotherapy, epidurals, facet, nerve blocks, radiofrequency ablation) \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does pain impact your daily activities, sleep, or emotional well-being?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the last 12 months, have you been hurt or threatened? \_\_\_Yes \_\_\_No

During the past month, have you felt “down” or depressed? \_\_\_Yes \_\_\_No

Do you have trouble finding pleasure in things you used to enjoy? \_\_\_Yes \_\_\_No

Have you ever been so sad that you thought about harming yourself? \_\_\_Yes \_\_\_No

**Functional Status**

Have you experienced any change in your ability to do your usual activities? \_\_\_Yes \_\_\_No

Are you receiving any special help at home? \_\_\_Yes \_\_\_No

Have you had 3 or more falls in the past year? \_\_\_Yes \_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any difficulty bathing or dressing yourself? \_\_\_Yes \_\_\_No

Do you ever lose control over your urination or bowel movements? \_\_\_Yes \_\_\_No

Do you have an Advance Health Care Directive/Living Will/Durable Power of Attorney? \_\_\_Yes \_\_\_No

Would you like information about Advance Directives? \_\_\_Yes \_\_\_No \_\_\_ Unsure

**Substance history** *If yes for any of the following, please complete additional questions:*

Do you drink alcohol? \_\_\_Yes \_\_\_No

*During the last week, how many days have you had a drink? \_\_\_\_\_\_*

*On days when you had a drink, how many drinks (beer, wine, or liquor) did you have? \_\_\_\_\_\_*

*Do you have any concerns about your alcohol use? \_\_\_Yes \_\_\_No*

Do you take tobacco products? \_\_\_Yes \_\_\_No

*What form(s)? \_\_\_ cigarettes \_\_\_ vape \_\_\_ gum \_\_\_ patch. How many times in a day?\_\_\_*

*How many years? \_\_\_\_\_ Quit date? \_\_\_\_\_\_\_\_ How many packs of cigarettes per day? \_\_\_\_\_*

Have you been exposed to second-hand smoke? \_\_\_Yes \_\_\_No

Have you ever injected any substance? \_\_\_Yes \_\_\_No

Have you ever taken cocaine, stimulants, opioids, or other substance? \_\_\_Yes \_\_\_No

*If yes, please describe:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E. SOCIAL AND CULTURAL HISTORY**

What is your employment status? \_\_\_Full-time \_\_\_Part-time \_\_\_Unemployed \_\_\_Retired \_\_\_Other

What is/was your occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live alone? \_\_\_Yes \_\_\_No *If no, who do you live with?*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status:\_\_\_Single \_\_\_Married \_\_\_Divorced \_\_\_Widowed \_\_\_Partnered \_\_\_Prefer no answer

What are the major stressors in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What helps you cope with stress?

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Please describe your interests and hobbies:

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Please describe your support system (e.g., family, friends, community, groups, pets):

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Do you have any cultural, religious practices, or spiritual beliefs you would like to share with us?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please share how you and/or your family/caregiver learn best (e.g. written, visual, audio, etc.)?

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**F. REVIEW OF SYSTEMS**

***Please check if you have experienced any of the following in the past 3-6 months:***

|  |  |
| --- | --- |
| \_\_\_ Abdominal pain  \_\_\_ Allergy symptoms  \_\_\_ Appetite changes  \_\_\_ Black or bloody stools  \_\_\_ Breast pain, lump, or swelling  \_\_\_ Breathing problems  \_\_\_ Bruising or bleeding easily or frequently  \_\_\_ Changes in general health  \_\_\_ Chest pain  \_\_\_ Chronic cough  \_\_\_ Chronic sinus problems or runny nose  \_\_\_ Confusion, convulsions, seizures, or blackouts  \_\_\_ Constipation  \_\_\_ Coughing-up blood  \_\_\_ Diarrhea  \_\_\_ Dizziness or lightheadedness  \_\_\_ Excessive stress  \_\_\_ Excessive thirst or urination  \_\_\_ Eyes: pain, irritation, redness, or discharge  \_\_\_ Fatigue  \_\_\_ Fevers, chills, or sweats  \_\_\_ Hair or nail changes  \_\_\_ Headaches  \_\_\_ Hearing changes or ringing in ears | \_\_\_ Heartburn  \_\_\_ Heat or cold intolerance  \_\_\_ Joint or muscle stiffness  \_\_\_ Infections (recurrent or possible)  \_\_\_ Memory or concentration changes  \_\_\_ Nausea or vomiting  \_\_\_ Nervousness or anxiety  \_\_\_ Numbness or tingling  \_\_\_ Pain in neck or back  \_\_\_ Palpitations  \_\_\_ Sadness or depression  \_\_\_ Shortness of breath  \_\_\_ Sleep difficulties  \_\_\_ Sore throat  \_\_\_ Special messages, visions, or voices  \_\_\_ Swallowing difficulties  \_\_\_ Swelling of feet, ankles, hands  \_\_\_ Toxic exposure (e.g., mold, pesticides)  \_\_\_ Unusual rash or skin problems  \_\_\_ Visual changes  \_\_\_ Vocal changes  \_\_\_ Walking difficulties  \_\_\_ Weakness or paralysis  \_\_\_ Weight changes |

**Is there anything else you would like to discuss or want our team to know?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*OPTIONAL: If your MyChart/CareEverywhere records are not current, please answer the following**

**PAST MEDICAL HISTORY**.  *Please circle Yes or No for any illnesses you have had:*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Anemia | Yes | No |  | Hepatitis | Yes | No |
| Arthritis | Yes | No |  | High Blood Pressure | Yes | No |
| Asthma, Bronchitis, or Emphysema | Yes | No |  | Immune Condtions | Yes | No |
| Bleeding or Bruising | Yes | No |  | Intestinal Conditions | Yes | No |
| Blood Disorder | Yes | No |  | Kidney Condition | Yes | No |
| Cancer (type): | Yes | No |  | Liver Condition | Yes | No |
| Depression or Anxiety | Yes | No |  | Lung Condition | Yes | No |
| Diabetes | Yes | No |  | Skin Condition | Yes | No |
| Epilepsy or Seizures | Yes | No |  | Stroke | Yes | No |
| Hay Fever or Sinus Conditions | Yes | No |  | Stomach Ulcers | Yes | No |
| Heart Condition | Yes | No |  | Thyroid Condition | Yes | No |

\*If the condition(s) is not listed, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you ever been hospitalized?** \_\_\_Yes \_\_\_No*If yes, please list the date(s) and reason(s):*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you had any surgeries?** \_\_\_Yes \_\_\_No *If yes, please list the date(s) and type(s) of surgeries:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you have any allergies?** \_\_\_Yes \_\_\_No *If yes, please list below:*

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| --- | --- |
| **Allergen:** *medication, environmental, substance* | **Reaction** |
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**Please answer any of the following questions if applicable to you:**

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| --- | --- |
| **Sexual Health** | *Additional information* |
| Do you have any concerns about your sexual health? \_\_\_Yes \_\_\_No |  |
| Have you had sex with women? \_\_\_Yes \_\_\_No |  |
| Have you had sex with men? \_\_\_Yes \_\_\_No |  |
| Have you had sex with non-binary partners? \_\_\_Yes \_\_\_No |  |
| Do you and your sexual partner(s) practice safe sex? \_\_\_Yes \_\_\_No \_\_\_Unsure |  |
| Have you ever had a sexually transmitted disease? \_\_\_Yes \_\_\_No \_\_\_Unsure |  |

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| --- | --- |
| **Women’s Health** | *Additional information* |
| Do you have problems with any of the following? *If yes, please check*  \_\_\_\_ Urinary frequency, urgency, urination at night  \_\_\_\_ Lack of bladder control, incontinence, or painful urination  \_\_\_\_ Blood in urine  \_\_\_\_ Recurrent urinary tract infections, or vaginal discharge  \_\_\_\_ Vaginal pain, itching, irritation, or vaginal dryness  \_\_\_\_ Hot flashes  \_\_\_\_ Change in sex drive  \_\_\_\_ Bleeding between periods or after menopause |  |
| Have you ever had a mammogram? \_\_\_Yes \_\_\_No  *If yes, note date, results, and where it was done:* |  |
| Have you ever had an abnormal mammogram? \_\_\_Yes \_\_\_No  *If yes, note date, results, and treatment:* |  |
| Do you routinely practice self-breast exams? \_\_\_Yes \_\_\_No |  |
| When was your last PAP smear? \_\_\_Yes \_\_\_No |  |
| Have you ever had an abnormal PAP smear? \_\_\_Yes \_\_\_No  *If yes, note date, results, treatment* |  |
| How old were you when you had your first menstrual period? Age \_\_\_\_ |  |
| Do you still have menstrual periods? \_\_\_Yes \_\_\_No |  |
| *If you are still having periods, on what day did last period start? \_\_\_/\_\_\_/\_\_\_* |  |
| *Are your periods regular?* \_\_\_Yes \_\_\_No |  |
| *Are your periods painful?* \_\_\_Yes \_\_\_No |  |
| *How many days are there between periods? \_\_\_\_ days* |  |
| *How long does your period last? \_\_\_\_ days* |  |
| *How would you describe your periods?* |  |
| Have you ever been on hormone replacement therapy?\_\_\_Yes \_\_\_No  *If yes, note dates and type:* |  |
| Have you ever been pregnant? \_\_\_Yes \_\_\_No  *Write the total number of pregnancies, deliveries, miscarriages, abortions:*  *Did you have complications with a pregnancy?* \_\_\_Yes \_\_\_No |  |
| Do you currently use any form of birth control?\_\_\_Yes \_\_\_No |  |
|  |  |
| **Men’s Health** | *Additional information* |
| Have you had problems with the following.  *If yes, please check:*  \_\_\_\_ Testicular pain  \_\_\_\_ Impotence / change in sexual function  \_\_\_\_ Prostate problems  \_\_\_\_ Difficulty starting stream urinary frequency  \_\_\_\_ Frequent urination at night  \_\_\_\_ Lack of bladder control, dribbling, or painful urination  \_\_\_\_ Blood in urine  \_\_\_\_ Recurrent urinary tract infections |  |
| Do you routinely practice testicular self-exams? \_\_\_Yes \_\_\_No |  |
| Have you had a PSA blood test? \_\_\_Yes \_\_\_No |  |
| Have you ever been screened for prostate cancer? \_\_\_Yes \_\_\_No *Was it a digital rectal exam?* \_\_\_Yes \_\_\_No |  |