

Osher Center for Integrative Medicine Clinical Practice

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION

DATE

# NEW PATIENT INTAKE FORM

1. What are your goals and / or health concerns for this visit?
2. What prior experiences have you had with alternative medicine?
3. Who is your primary care provider (PCP)
4. When was the last time you visited your PCP and for what reason(s)?
5. What other practitioners are you currently receiving care from?

**Nutrition**

1. Please describe your typical diet:

Breakfast Lunch Dinner Snacks

1. Do you change your eating habits when you are upset, worried, or sad? # Yes # No
2. Do you eat when you are rushed? # Yes # No
3. Do you skip meals? # Yes # No

# Breakfast # Lunch # Dinner

1. How many glasses of fluids (water, juice) do you drink a day?
2. How many cups/cans of caffeinated drinks (coffee, tea, soda) do you drink/day?

258-001A (Rev. 03/06) Relizon MEDICAL RECORD COPY Page 1 of 2

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1. List the vitamins/minerals/supplements you are presently taking?

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Reason** | **When you started** | **Dosage** |
| *Example: St. John’s Wort* | *Feeling Down* | *2 months ago* | *3 caps/day* |

1. Please list some of the major stressors in your life
2. Please describe your sleeping patterns
3. What do you do to relax?
4. What interests and hobbies do you have?
5. Describe your support system (family, friends, religion, spirituality, community/groups, pets):

Additional comments:

Patient or responsible person signature: Relationship to patient :

Date: / / Date: / /

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Page 2 of 2

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