UCSF Medical Center

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

6. Please describe your typical diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

7. Do you change your eating habits when you are upset, worried, or sad? ☐ Yes ☐ No

8. Do you eat when you are rushed? ☐ Yes ☐ No

9. Do you skip meals? ☐ Yes ☐ No

☐ Breakfast ☐ Lunch ☐ Dinner

10. How many glasses of fluids (water, juice) do you drink a day? _____

11. How many cups/cans of caffeinated drinks (coffee, tea, soda) do you drink/day? _____

12. 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*

13. Please list some of the major stressors in your life

_____

_____

_____

14. Please describe your sleeping patterns

_____

_____

_____

15. What do you do to relax?

_____

_____

_____

16. What interests and hobbies do you have?

_____

_____

_____

17. Describe your support system (family, friends, religion, spirituality, community/groups, pets):

_____

_____

_____

Additional comments:

_____

_____

Patient or responsible person signature: _____ Date: ____ / ____ / ____

Relationship to patient :_____ Date: ____ / ____ / ____