



Name: _____

Date of Birth: _____

SECTION I: INTEGRATIVE HEALTH CONSULTATION

What are your primary goals for this visit?

Please describe your prior experiences with Integrative Health:

A. TREATMENT TEAM

Primary Care Provider (PCP) _____ Preferred Lab: __UCSF __LabCorp __ Quest

Please list all members of your care team: _____

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 <i>Note type</i>	Caffeinated drinks <i>Note type (coffee, tea, etc.)</i>	Soda <i>Note type (diet, regular)</i>

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

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

Please describe your sleeping patterns:

Are you interested in mind-body practices (e.g., mindfulness, meditation, yoga)? Yes No
If yes, please describe:

To learn more about courses for mind-body wellbeing, please 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?
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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?

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

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?

What helps you cope with stress?

Please describe your interests and hobbies:

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

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

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

F. REVIEW OF SYSTEMS

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

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

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

SECTION II: If your MyChart/CareEverywhere records are not current, please answer the following:

PAST MEDICAL HISTORY. Please **Check** 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 Conditions	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 Conditons	Yes	No	Stomach Ulcers	Yes	No
Heart Condition	Yes	No	Thyroid Condition	Yes	No

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

Have you ever been hospitalized? ___Yes ___No *If yes, please list the date(s) and reason(s):*

Have you had any surgeries? ___Yes ___No *If yes, please list the date(s) and type(s) of surgeries:*

Do you have any allergies? ___Yes ___No *If yes, please list below:*

Allergen: medication, environmental, substance	Reaction

Please answer any of the following questions if applicable to you:

Sexual Health	<i>Additional information</i>
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	

Women's Health	<i>Additional information</i>
Do you have problems with any of the following? <i>If yes, please check</i> <input type="checkbox"/> Urinary frequency, urgency, urination at night <input type="checkbox"/> Lack of bladder control, incontinence, or painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Recurrent urinary tract infections, or vaginal discharge <input type="checkbox"/> Vaginal pain, itching, irritation, or vaginal dryness <input type="checkbox"/> Hot flashes <input type="checkbox"/> Change in sex drive <input type="checkbox"/> Bleeding between periods or after menopause	
Have you ever had a mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, note date, results, and where it was done:</i>	
Have you ever had an abnormal mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, note date, results, and treatment:</i>	
Do you routinely practice self-breast exams? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When was your last PAP smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had an abnormal PAP smear? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, note date, results, treatment</i>	
How old were you when you had your first menstrual period? Age ____	
Do you still have menstrual periods? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If you are still having periods, on what day did last period start? ___/___/___</i>	
<i>Are your periods regular?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Are your periods painful?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>How many days are there between periods?</i> ____ days	
<i>How long does your period last?</i> ____ days	
<i>How would you describe your periods?</i>	
Have you ever been on hormone replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, note dates and type:</i>	
Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Write the total number of pregnancies, deliveries, miscarriages, abortions:</i> <i>Did you have complications with a pregnancy?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently use any form of birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Men's Health	<i>Additional information</i>
Have you had problems with the following. <i>If yes, please check:</i> <input type="checkbox"/> Testicular pain <input type="checkbox"/> Impotence / change in sexual function <input type="checkbox"/> Prostate problems <input type="checkbox"/> Difficulty starting stream urinary frequency <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Lack of bladder control, dribbling, or painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Recurrent urinary tract infections	
Do you routinely practice testicular self-exams? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had a PSA blood test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been screened for prostate cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Was it a digital rectal exam?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	