UCSF Osher Center for Integrative Health

New patients must submit this completed form no later than one week before the first visit
Email: OsherNP@ucsf.edu | Fax: (415) 353-7358 | Phone: (415) 353-7700.

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 *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:

_____

_____

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?

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:

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

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

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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 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: _____

_____

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	*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	