UC Health Integrative Medicine

UC Health Physicians Office Midtown
3590 Lucille Drive, Suite 2400
Cincinnati, OH 45213

UC Health Physicians Office South
7675 Wellness Way, 4th Floor
West Chester, OH 45069

UC Health Barrett Cancer Center
234 Goodman Street, 2nd Floor
Cincinnati, OH 45219

P (513) 475-9567
F (513) 458-1989

UCHealth.com/Integrative

Dear Valued Patient,

Thank you for your interest in UC Health Integrative and Functional Medicine clinical services. We are glad you are exploring your health care options and look forward to partnering with you to meet your health goals.

Integrative Medicine combines conventional medicine with evidence-based complementary therapies with a focus on healthy lifestyle to address behavior, nutrition, movement, sleep, and your environment to reduce stress and promote overall wellness.

To better serve you and all of our patients, UC Health Integrative Medicine ***requires all new patients complete and return the New Patient Intake Questionnaire along with a copy (front/back) of their insurance card prior to being scheduled for their first appointment***. This improves our providers' ability to best serve your needs, while simultaneously increasing access allowing more new patients into the program, and assisting with the wait time for an initial appointment with our physicians.

1) **New Patient Intake Questionnaire:**
   a. Attached is our New Patient Intake Questionnaire, please complete and send back to us.

We strongly encourage you keep a copy of this paperwork for your records

You can send the attached paperwork by:

1. Emailing: Cheryl.Smith@uchealth.com
2. Fax: (513) 458-1989 Attn: Cheryl Smith
3. Mailing to: *(Please allow 21 days for USPS mail deliveries)*
   UC Health Physicians Office Midtown
   Attn: Integrative Medicine
   3590 Lucille Drive, Suite 2600
   Cincinnati, OH 45213

Our multi-disciplinary team not only reviews health concerns that may not have responded well to modern/conventional medical approaches, but also helps patients with preventing diseases they wish to avoid.

Our aim is to help people feel *truly well*. We look forward to your first visit and partnering with you on your wellness!

-Your Integrative Medicine Care Team

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UC Health Integrative Medicine Appointment Policy

Effective April 2017

We respect your time. That is why, we are implementing an Appointment Policy to address no shows, cancellations and late arrivals. We hope this policy will help our continued focus on better serving our patients and providing excellent customer service.

1. **Arrival Time:**
   - **a. New Patients**
     - i. New Patients are expected to arrive 30 minutes before scheduled appointment time. This allows time for check in and optimizes time with your provider.
   - **b. Established Patients**
     - i. All Established Patients are expected to arrive 15-20 minutes before scheduled appointment time.

Please be mindful of your appointment time. Arriving at the exact time of your scheduled appointment causes delays not only, for you but also, for patients being seen after you.

2. **Arriving Late to Appointments:**
   - a. Patients arriving 15 minutes or later to their scheduled appointment may be asked to reschedule their appointment.
3. **Cancellations & Rescheduling of Appointments:**
   - a. We require 24-hour cancellation or rescheduling notice for all office appointments.
   - b. Cancellations less than 24 hours in advance will be considered a "no show".
4. **Dismissal from Practice:**
   - a. Should a patient late cancel or "no show" their scheduled office appointment 3 times with any of our UC Health Integrative Medicine providers, it may result in dismissal from the practice.

Patient Name: _____

Patient Signature: _____

Date: _____

***This policy is subject to change at any time. ***

UC Health Integrative Medicine
UC Health Midtown Office
3590 Lucille Drive, Suite 2400
Cincinnati, Ohio 45213
P (513) 475-WLNS (9675)

www.UCHealth.com/Integrative

New Patient Intake Questionnaire

Please complete all information on this questionnaire as accurately and completely as possible. We also ask that you send a copy (front/back) of your insurance card with this paperwork. All information will be treated as strictly confidential. If you have questions, please consult your Integrative Medicine practitioner or call us at 513-475- 9567(WLNS).

Date: _____ Integrative Medicine Appointment Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Best Daytime Phone: (_____) _____ Secondary Phone: (_____) _____

Insurance Provider: _____

Educational History (Check all that apply): Still in school/training ☐ GED ☐ High school /Trade school ☐

Two year degree ☐ Four year degree ☐ Graduate degree ☐

Employment: Paid work 40 or more hrs/week ☐ Paid work less than 40 hrs/week ☐ Between jobs ☐

Disabled ☐ Fulltime Home maker ☐ Retired ☐

Relationships: Single ☐ Married ☐ Long term partnership ☐ Separated/Divorced ☐ Widowed ☐

I live with: No one else ☐ Spouse ☐ Domestic partner ☐ Children ☐ Pets ☐ Others ☐

I live in a(n): Apartment ☐ Condo ☐ Single Family Home ☐ Multi-family home ☐

Length of time in current home: < 1 year ☐ 1-2 years ☐ 3-5 years ☐ > 5 years ☐

Health

How many times do you see a primary care doctor each year: 1 ☐ 2 ☐ 3 ☐ 4+ ☐

Which specialists do you see regularly or at least yearly: Dermatology ☐ Ear, Nose, Throat ☐ Endocrinology ☐

Eye ☐ GI/Gut ☐ Gyn/Ob ☐ Hematology ☐ Kidney ☐ Liver ☐ Lung ☐ Neurology ☐ Oncology ☐
Ortho ☐ Pain ☐ Podiatry ☐ Psychiatry ☐ Rheumatology ☐ Surgery ☐ Other _____

How many prescribed pills do you take each day? 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+ ☐

How many over the counter supplement pills do you take each day? 0 ☐ 1-2 ☐ 3-5 ☐ 6-9 ☐ 10+ ☐

Dental health: Cavities/fillings ☐ Dentures ☐ Grinding ☐ Gum disease ☐ Root canals ☐ TMJ ☐

Current habits: Alcohol ☐ Recreational drugs ☐ Soda pop/cola ☐ Tobacco ☐

Past habits: Alcohol ☐ Recreational drugs ☐ Soda pop/cola ☐ Tobacco ☐

Daily hydration: No water ☐ 1-2 (8 oz) cups water ☐ 3-4 cups water ☐ 5-6 cups water ☐ 7+ ☐

Sleep: Trouble falling asleep? Yes ☐ No ☐ Trouble waking up? Yes ☐ No ☐

Wake up too early? Yes ☐ No ☐ Frequent awakening? Yes ☐ No ☐ Sleep apnea? Yes ☐ No ☐

Energy: I start the day fresh/energetic ☐ I can't start the day without coffee or other booster ☐

I'm ok in the morning but tired mid-afternoon ☐ I'm always tired, no part of day better or worse ☐

Movement (work related): Mainly sitting ☐ Up and down ☐ Mainly active ☐

Office use:
MCV
Ferritin
B12
MMA
Hcy

Family History (Parents, Siblings, Children): Autoimmune issues (rheumatoid arthritis, celiac, Hashimoto's, vitiligo, psoriasis, etc.) ☐ Cancer ☐ Dementia/Alzheimer's ☐ Diabetes ☐ Heart Disease ☐ Intestinal problems ☐ Overweight ☐ Thyroid ☐

Immune System

Do you have environmental allergies (grass, dust, environmental)? Yes ☐ No ☐ Comes/goes ☐ Year round ☐

Approximately how many courses of antibiotics have you had in the past 10 years: 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐

Approximately how many courses of antibiotics have you had prior to the past 10 years: <5 ☐ 5-10 ☐ 10+ ☐

Approximately how many steroid/prednisone courses (by mouth or injection) have you had in the past 10 years:

0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐

Office use:
ESR
CRP
Vit D

Hormones (male, female, thyroid, adrenal, insulin)

I have given birth to or fathered a child: Yes ☐ No ☐ I think I have problems with my hormones: Yes ☐ No ☐

I am sexually intimate with another person/s: Yes ☐ No ☐

Office use:
TSH
T3
RT3

Please rank your concerns about each body area:

Point scale: 0 - No concern 1 – occasional 2 – mild 3 - moderate 4 - High concern

_____ Weight	_____ Mouth/Teeth	_____ Breast	_____ Shoulders
_____ Skin	_____ Throat	_____ Abdomen	_____ Legs
_____ Hair	_____ Neck	_____ Liver/Kidneys	_____ Hips
_____ Head	_____ Thyroid	_____ Mid back	_____ Knees
_____ Eyes	_____ Chest	_____ Low back	_____ Feet
_____ Ears	_____ Lungs	_____ Arms	_____ Female/male parts
_____ Nose			

Nutrition/Digestion

Height: _____ Current Weight: _____

Do you have problems with any of the following? Bloating/distended belly ☐ Indigestion/heartburn ☐

Nausea and/or vomiting ☐ Belching/burping ☐ Diarrhea ☐ Constipation ☐

Describe your bowel frequency: Once daily ☐ Several daily ☐ Once every 2-3 days ☐ Once every 4+ days ☐

Have you had any intestinal surgery? Gall bladder ☐ Stomach ☐ Appendix ☐ Part of colon ☐

Bariatric/lap band ☐ Other _____

Have you made changes in your eating habits because of your health? Yes ☐ No ☐

Do you currently follow a special "diet" or nutritional program? Yes ☐ No ☐

Do you have problems with any of the following foods? Dairy ☐ Eggs ☐ Fat ☐ Fruits ☐ Nuts ☐ Meats ☐

Soy ☐ Sugar ☐ Wheat ☐ None ☐ Other _____

How many vegetable servings do you eat in a day? 0 ☐ 1-3 ☐ 4-6 ☐ 7+ ☐

How many fruit servings do you eat in a day? 0☐ 1-3 ☐ 4-6 ☐ 7+ ☐

Do you use artificial sweeteners? Yes ☐ No ☐

Food Journal

Please record what you eat and drink for one 24-hour period. Include all beverages, creamers, sweeteners, condiments added to any of your foods/beverages.

Time	Food/Beverage items	Amount *(e.g. cups, oz.)*

Emotional and Behavioral Health:

What do you do for **fun/relaxation**? _____

What brings you joy? _____

_____

What seems to leave you feeling depleted/ low energy? _____

_____

How would you rate your **current level of stress**?

Low – 0 1 2 3 4 5 6 7 8 9 10 - High

In what ways do you regularly manage stress: Acupuncture ☐ Deep Breathing ☐ Drinking Alcohol ☐ Eating ☐
Exercise ☐ Journaling ☐ Massage ☐ Meditation ☐ Praying ☐ Talking to Family/Friends ☐ Sleep ☐
Sex ☐ Yoga ☐ Other: _____

What is your **biggest obstacle** or **barrier** to you feeling your best? _____

_____

How would you describe your ***current level*** of emotional and/or spiritual support?

Very poor 0 1 2 3 4 5 6 7 8 9 10 Very good

How would you describe your ***current level*** of anxiety?

No problem 0 1 2 3 4 5 6 7 8 9 10 Major problem

During the last 30 days, how often have you felt Sad or Down/depressed?

Never 0 1 2 3 4 5 6 7 8 9 10 Consistently

To what degree do you feel hopeful about your health/resolving your issues?

Little or no hope 0 1 2 3 4 5 6 7 8 9 10 Very Hopeful!

If you ***felt your best***, what would you do **differently** and how would this change your life?_____

_____

Indicate your ***current readiness*** to take action regarding your health goals:

Not ready to change 0 1 2 3 4 5 6 7 8 9 10 *Already changing*

How important is religion (or spirituality or faith) for you and for your family?

Not at all important ☐ Somewhat important ☐ Extremely important ☐

Have you experienced any major losses/trauma in life? Yes ☐ No ☐

If yes, was this (check all that apply): In childhood? ☐ Teens? ☐ Adulthood? ☐ In past five years? ☐

I prefer to discuss these matters in person: Yes ☐ I prefer not to discuss at all (keep private): Yes ☐

Unfortunately, abuse and violence of all kinds including verbal, emotional, physical and sexual are leading contributors to chronic stress and illness. Witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it so we may support you and optimize your treatment outcomes. If you would feel safer discussing these issues with us in private, or not at all, please simply mark "discuss in person" or "keep private" and move to the next section.

How safe did you feel growing up?

Not safe 0 1 2 3 4 5 6 7 8 9 10 *Very safe*

Have you been involved in abusive relationships?	Yes ☐	No ☐
Was the abuse of alcohol or other substances present in your childhood home/relationships?	Yes ☐	No ☐
Is the abuse of alcohol or other substances present in your current home/relationships?	Yes ☐	No ☐
How safe do you currently feel in your home?	Yes ☐	No ☐
Do you currently feel safe, respected and valued in your current relationship/s?	Yes ☐	No ☐
Have you had any violent or otherwise traumatic life experiences?	Yes ☐	No ☐
Have you witnessed any violence or abuse?	Yes ☐	No ☐

Please check any **complementary treatments** that you have tried, if they have helped or not, and if you are currently using them:

Therapy:	**Tried?**	**Helpful?**	**Currently Use?**
Physical therapy	☐	Yes ☐ No ☐	☐
Talk therapy/Counseling	☐	Yes ☐ No ☐	☐
Massage therapy	☐	Yes ☐ No ☐	☐
Yoga	☐	Yes ☐ No ☐	☐
Chiropractic	☐	Yes ☐ No ☐	☐
Acupuncture	☐	Yes ☐ No ☐	☐
Meditation	☐	Yes ☐ No ☐	☐
Tai Chi/Qigong	☐	Yes ☐ No ☐	☐

Anything else you would like us to know about you?

Thank you!