UC Health Integrative Medicine

UC Health Physician's Office Midtown
3590 Lucille Drive, Suite 2400
Cincinnati, OH 45213

UC Health Physician's Office South
7675 Wellness Way, 4th Floor
West Chester, OH 45069

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

UC Health Hoxworth Center
3130 Highland Ave,
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's Integrative and Functional Medicine clinical services. We 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.

Dr. Barbara Walker's practice focuses on health and performance psychology partners with individuals to achieve their optimal energy, health, and performance using a skill-based educational approach to mind-body medicine using modalities such as biofeedback, relaxation training, mindfulness, solution oriented cognitive behavioral strategies with the goal of self-regulation. Areas such as sleep, movement, exercise, eating behavior are addressed.

To better serve you and all of our patients, UC Health Integrative Medicine ***requires all new patients to 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 better serve your needs, while simultaneously increasing access allowing more new patients into the program. *If you need assistance filling out this form, please contact the office at 513-475-WLNS (9567).*

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 your paperwork and a copy of your insurance card (front/back) by:

1. Emailing: Amber.Jacobs@UCHealth.com
2. Fax: (513) 458-1989 Attn: Amber Jacobs
3. Mailing to: *(Please allow 21 days for USPS mail deliveries)*

   **UC Health Physician's Office Midtown**
   **Attn: Integrative Medicine**
   **3590 Lucille Drive, Suite 2400**
   **Cincinnati, OH 45213**

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*

If you have any questions, feel free to contact us at 475- WLNS (9567) or email: Amber.Jacobs@UCHealth.com

# 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 15 minutes before scheduled appointment time. This allows time for check in and optimizes time with your provider. Your new patient questionnaire should be completed and returned by your scheduled appointment time.
    b. **Established Patients**
        i. All Established Patients are expected to arrive 10-15 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: _____
Date of Birth: _____
Patient Signature: _____
Date: _____

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

# UC Health Integrative Medicine


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3590 Lucille Drive Suite 2400
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234 Goodman Street 2nd Fl
CINCINNATI OH 45219

West Chester
7675 Wellness Way Suite 400
West Chester OH 45069

**Phone:** (513) 475-WLNS (9567) **Fax:** (513) 458-1989 **Website:** UCHealth.com/Integrative


## Health and Performance Psychology New Patient Questionnaire

*In order for us to provide a comprehensive evaluation, please complete all information on this intake questionnaire as accurately and completely as possible. All information will be treated as strictly confidential.*

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

Referred by: _____

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

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

Emergency Contact Name and Phone: _____

Email address: _____

**Educational History**: Which levels of study have you completed? ☐ Still in school/training: _____

☐ Middle school ☐ High school /Trade school ☐ Two-year college ☐ Four-year college ☐ Graduate school

**Current Employment**: _____

Occupation: _____

**Personal Relationships:**

What is your marital status? Single ☐ Married ☐ When?_____ Long term partnership ☐ Since when?_____
Divorced ☐ When?_____ Widowed ☐ When?_____

With whom do you currently live? _____

**Primary Reason for Consultation**: (Please check any and all that apply + add any additional details)

☐ Sport Psychology
☐ Performance Issues
☐ Stress Management/Relaxation
☐ Management of Depression/Fatigue
☐ Management of Anxiety Symptoms
☐ Career Management
☐ Biofeedback
☐ Discuss coping strategies regarding recent diagnosis
☐ Seeking behavioral strategies to improve _____
☐ Mindfulness/Meditation
☐ Family Issues
☐ Conflict Resolution

☐ Other: _____

What are the top three objectives that you would like to achieve as a result from our sessions?

1. _____
2._____
3. _____

Managing Stress

What are your Current Stressors, including any perceived barriers that are inhibiting you from reaching your goals?

_____
_____
_____

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Low – | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - High |

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/no hope - | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 - Very Hopeful! |

How do you feel you are currently coping with life in general?

☐ Seldom stressed ☐ Sometimes stressed ☐ Often stressed ☐ Heavily stressed ☐ Excessively stressed

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: _____

Where do you feel that you typically carry stress in your body? (check all that apply):

| | | |
|---|---|---|
| ☐ Head (difficulty concentrating/too many thoughts) | | ☐ Tension Headaches |
| ☐ Migraines | ☐ Shoulder/Traps | ☐ Back |
| ☐ Overall muscle tightness | ☐ Gastro-Intestinal Symptoms | |

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

What brings you joy? _____
_____

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

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

_____

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

_____

## Past history:

Have you ever seen a counselor or therapist? ☐Yes ☐No ☐ Currently? ☐Yes ☐No ☐
Reason: _____

Do you have any history of:

| | | | |
|---|---|---|---|
| | Verbal, physical, sexual or emotional abuse? ☐Yes ☐No | | ☐Currently |
| | Alcohol Dependency | ☐Yes ☐No | ☐Currently |
| ☐ | Anxiety | ☐Yes ☐No | ☐Currently |
| ☐ | Depression | ☐Yes ☐No | ☐Currently |
| | Suicidal Ideation or Attempts | ☐Yes ☐No | ☐Currently |
| ☐ | Substance Abuse | ☐Yes ☐No | ☐Currently |
| | Eating Disorder | ☐Yes ☐No | ☐Currently |

How supportive are your family and friends? ☐Very ☐Somewhat ☐Not very supportive

## Personal Habits:

## Sleep Routine:

On average, how many hours of sleep do you usually get per night? _____

How many times do you typically wake up through the night? _____

What do you usually do when you awaken during the night?_____

Do you read before falling asleep? ☐Yes ☐No If yes, do you read a book or e-reader? _____

Do you watch TV before falling asleep? ☐Yes ☐No Is the TV in the bedroom? ☐Yes ☐No

Do you work on a computer/laptop/smartphone before falling asleep or during the night? ☐Yes ☐No

Please describe any problem(s)/concerns you feel you have with your sleep. Include when and how this started affecting you or your family members, what treatment you have received for this in the past.

_____

_____

_____

_____

## Eating Habits:

Please describe the quantity and frequency of your use of the following DAILY:

| | | | | | |
|---|---|---|---|---|---|
| Vegetable servings: | 0 | 1-3 | 4-6 | 7+ | |
| Fruit servings: | 0 | 1-3 | 4-6 | 7+ | |
| Cups of Water: | 0 | 1-3 | 4-6 | 7-9 | 10+ |
| Homemade meals: | 0 | 1 | 2 | 3 | |
| Fast food meals: | 0 | 1 | 2 | 3 | |
| How many snacks: | 0 | 1 | 2 | 3 | |
| Sugary Beverages: | 0 | 1 | 2 | 3+ | |
| Diet Beverages: | 0 | 1 | 2 | 3+ | |
| Alcohol: | 0 | 1 | 2 | 3+ | |
| Fried Foods: | 0 | 1 | 2 | 3+ | |

Movement/Exercise Routine:

How much of your waking day is spent sitting? ☐☐Very little ☐ About half the day ☐☐Most of the day

What types of movement, exercise, and/or sports are you currently engaged in and how often? _____

_____

_____

What medical conditions or injuries have you had in the past and may be experiencing currently?

_____

_____

Please list all mediations (NON-PRESCRIPTION and Prescription), supplements, herbal and vitamin/mineral products. Indicate the form of supplement if possible (e.g., calcium carbonate vs calcium lactate). If additional space needed, please use a separate piece of paper.

_____

_____

Please 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*