



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 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 kindly asks that you complete and bring with you the attached **New Patient Acupuncture Intake Questionnaire** along with your photo ID and insurance card to your first appointment.

If you need assistance filling out this form, please contact the office at 513-475-WLNS (9567).

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 Luke.Underhill@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. ***

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Phone: (513) 475-WLNS (9567)

Fax: (513) 458-1989

Website: UCHHealth.com/Integrative

New Patient Acupuncture Intake Questionnaire

Name		Age:		Today's date:	/	/	/
Primary Complaint							Severity: /10
Secondary Complaint/s							Severity: /10
Current Diagnoses (all)							

Please Fill Out the Following Information and Check the Appropriate Boxes

What stress factors do you experience? (home/work/school etc): _____

Exercise/Movement: _____ X's per week for about _____ minutes

☐ Run ☐ Walk ☐ Bike ☐ Swim ☐ Weights ☐ Other: _____

Mind-Body: _____ X's per week for about _____ minutes

☐ Yoga ☐ Tai Chi ☐ Qigong ☐ Meditation ☐ Other: _____

Hobbies: _____

Spiritual Practice/s: _____ ☐ Daily ☐ Weekly ☐ Other: _____

What helps you: Relax? _____

What helps you: Feel Safe? _____

What makes you happy? _____

Are you unable to do things you enjoy? What are they? _____

When were you healthiest and most happy? What were you doing at that time? _____

Consistently experience:

- | | | | | | | |
|-----------------------------------|---------------------------------------|--------------------------------------|---------------------------------|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sadness | <input type="checkbox"/> Worry | <input type="checkbox"/> Sadness | <input type="checkbox"/> Fear | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain |

Interfering with:

- ☐ Work ☐ Sleep ☐ Relationships ☐ Digestion ☐ Other: _____

Sleep:

- ☐ Good ☐ Poor ☐ Restless ☐ Active dreams ☐ Difficult to fall or stay asleep

Regularly use on the skin:

- | | | | | | | |
|----------------------------------|----------------------------------|---|---------------------------------------|----------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Lotion | <input type="checkbox"/> Oil | <input type="checkbox"/> Essential oil | <input type="checkbox"/> Cream | <input type="checkbox"/> Extract | <input type="checkbox"/> Plaster | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Perfume | <input type="checkbox"/> Cologne | <input type="checkbox"/> Antiperspirant/deodorant | <input type="checkbox"/> Other: _____ | | | |

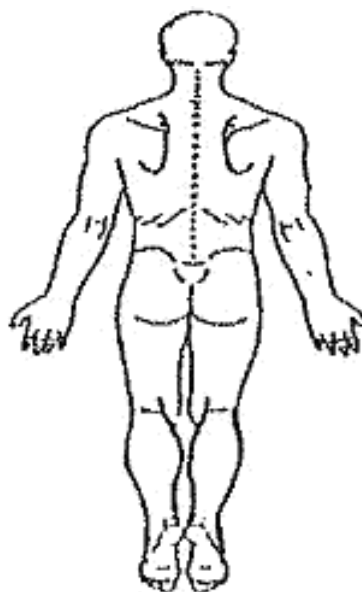
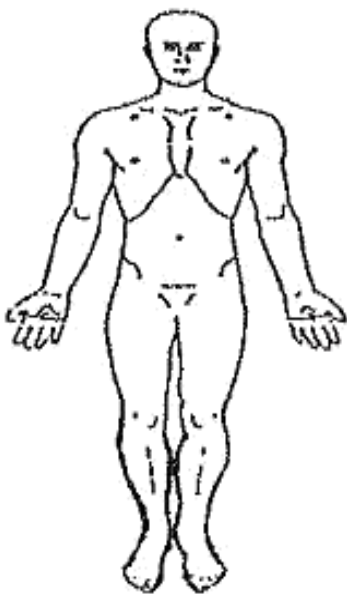
Please specify: _____

Food/product sensitivities: _____

How would you rate your quality of life? ____/10

Please make sure to complete a three (3) day food diary. This should include all foods, liquids & products you ingest as well as a list of your current medications and supplements.

Please indicate problem areas where applicable



Please Indicate All Symptoms You Are Experiencing or That Frequently Occur

General

- | | |
|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Insomnia/disturbed sleep | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Strong or No thirst | <input type="checkbox"/> Fever/chills |
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Hot hands/feet |
| <input type="checkbox"/> Easy or difficult to sweat | <input type="checkbox"/> Sudden fatigue |

Other: _____

Head/Eyes/Ears/Nose/Throat

- | | |
|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Earache/infection |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Difficulty hearing |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Eye pain/twitching | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Tired vision | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sores on lips/tongue |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tightness in throat |

Other: _____

Gastrointestinal

- | | |
|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heart burn |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/bloating |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Chronic laxatives | <input type="checkbox"/> Hemorrhoids |

Other: _____

Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heartbeat/pulse | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Fainting |

Other: _____

Respiratory

- | | |
|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain during inhale |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Chronic infections |
| <input type="checkbox"/> Asthma | |

Other: _____

Reproductive and Gynecologic

- | | |
|---|--|
| <input type="checkbox"/> Premenstrual changes | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Premature birth | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Menstrual clots | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Cysts or fibroids |
| <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Irregular cycle |
| <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Endometriosis |

Other: _____

Musculoskeletal/Pain

- | | |
|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Traumatic injury |
| <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sports injury |

Other: _____

Skin and Hair

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Ulceration | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Change in texture |

Other: _____

Genitourinary

- | | |
|---|---|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Male impotence |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Frequent night urination |

Other: _____

Neuro/psychological

- | | |
|--|--|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Loss of function |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Abnormal emotions |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> High Stress |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Anxiety |

Other: _____