Aiken-Augusta Holistic Health
Integrative Medicine initial patient information form (adult)

Name: Appointment Date & Time:

Date of birth: Best contact phone number:

E-mail: Mailing address:

Primary Care Provider: Contact info (phone, e-mail):

Referring Provider: Contact info (phone, e-mail):

Please attach medical records as appropriate.
May I send a summary to your doctor? Yes ☐ No ☐

Concern (please rank by priority)	Onset	Frequency	Severity
Ex. Headache	*June 99*	*4 times/wk*	*Mild/mod/severe*
1._____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

What are your goals for this visit?

_____
_____
_____
_____

What medical conditions do you have or have you had?
Ex. Diabetes, breast cancer, high blood pressure.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient Name_____ Reviewed by/date _____

Have you had any surgical procedures or injuries?

What	*When*	*What*	*When*

Please list any prescription medications that you are taking now

Medication	*Reason*	*Year Started*	*Dosage*
Ex. Lipitor	*High cholesterol*	*1999*	*10 mg once a day*

Do you have any allergic reactions to medications?

Medication	*Reaction/Intolerance*

Patient Name_____ Reviewed by/date _____

Please list any supplements, vitamins or herbs you are taking now

Brand or Other name (manufacturer)	*Reason*	*Year Started*	*Dosage*
Ex. Siberian ginseng	*energy*	*2001*	*500 mg twice a day*

Occupation:

What interests/hobbies do you have?

With whom do you live? (Include roommates, partner, spouse, children, relatives, pets)

Name	*Age*	*Relationship*	*Name*	*Age*	*Relationship*

What physical activity do you participate in?

What are the major stressors of your life?

Patient Name_____ Reviewed by/date _____

What do you do to relax?

_____
_____

How many hours of sleep per night (average, or range)?

Religious affiliations/ faith communities, past and present

_____

To what degree does a faith community or religion provide support to you at this time?

_____

What complementary or alternative therapies have you experienced or explored?

_____
_____
_____
_____
_____

Tobacco? Never Smoked from age _____ to _____. _____ packs per day.
Alcohol? Never Estimated drinks per day _____.
Other drugs? Never Type & frequency _____

Medical conditions in your family *(eg. Heart disease, diabetes, cancer, others)*?

Specific condition	*Family member*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Nutrition History
Recall of dietary intake
*Please list **all** foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.*
*Breakfast*_____

_____

*Lunch*_____

_____

*Dinner*_____

_____

_____

Patient Name_____ Reviewed by/date _____

*Snacks*_____
_____

Is this a typical day? If not, why not? Please describe:
_____
_____

Are there any types or groups of foods you crave or eat a lot?
_____
_____

Are there any types or groups of foods you dislike or rarely eat?
_____
_____

What do you drink on a typical day?
_____
_____

What type of oil do you cook with? _____
What types of spreads do you add to your foods? _____

How many servings of fruit do you eat/drink each day? _____
Serving = 1 small piece of fruit, ½ cup juice, ½ cup canned or chopped fruit, ¼ cup dried fruit

How many servings of vegetables do you consume each day? _____
Serving = ½ cup raw or cooked, 1 cup fresh, green leafy vegetables, ¼ cup dried or 1 small piece.

Who buys groceries for your home?
Who cooks in your home?
How many meals are eaten outside the home per week?
How would you describe your relationship with food?
_____
_____
Is there anything else you feel it is important to review today?

Patient Name_____ Reviewed by/date _____