INTEGRATIVE MEDICAL CLINIC OF SANTA ROSA

HEALTH HISTORY & BACKGROUND INFORMATION

Completing this form prior to your appointment allows more time for discussion with your provider.

NAME:_____Age:_____Date:_____

1. What is your overall goal(s) in coming to IMC?

2. Do you have a primary care physician? Select One
   If Yes, who is your primary physician? _____

3. Do you have a Durable Power of Attorney for Health Care? Select One
   If Yes: Who is it and what is their phone number?_____

4 .Who lives with you in your home? _____

5. What do you consider your greatest health asset:

6. What do you consider your greatest health problem:

7. DO YOU HAVE any of the following conditions? If yes, are you under a doctors' care and who is the doctor?

- ☐ Cancer Type:
- ☐ Depression
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney/ Urinary
- ☐ Problems
- ☐ Neurological Conditions
- ☐ Stomach/GI Problems
- ☐ OTHER:

8. Do you have FAMILY MEMBERS with any of the following:

- ☐ Heart Disease, High Blood Pressure, Stroke or Diabetes
- ☐ Breast or Ovarian Cancer
- ☐ Colon Cancer
- ☐ Melanoma Skin Cancer
- ☐ History of Alcohol or Drug Addiction
- ☐ History of Violence or Abuse
- ☐ OTHER:

Women:

Number of Pregnancies: Live Births: Living Children/ ages: _____

Complications during pregnancy or delivery?_____

9. Known Allergies to Medications:_____

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10. Current list of Medicines, Vitamins, Herbs, and/or Supplements with doses:

_____
_____
_____
_____
_____

11 Past Surgeries/Hospitalizations? Please give reason and estimated dates:

_____
_____
_____
_____

12. Do you smoke cigarettes? Select One

13. How often do you consume alcohol: Select One What type: Select One

13. What is/was your occupation?_____

15. Do you: Wear your seat belt? Select Have working smoke detectors in your home? Select Or
Have guns in the home? Selec Practice safe sex? Select

16. How often do you exercise? ___ times per week ____ minutes at a time

17. How many meals per day do you usually eat? _____ At what times:_____
How many glasses of water do you usually drink per day?_____

18. Please describe a scenario when you would know you are well and meeting your health goals:

_____
_____
_____

19 . Please review the list below:

Activity	Have used in past	Worked well for me	Would like to try
Acupuncture			
Massage			
Chiropractic			
Nutrition			
Energy work			
Naturopathic Medicine			
Feldenkrais			
Tai Chi /Chi Gung			
Herbs, supplements			
Biofeedback			
Counseling/therapy			

_____

Other things we should know: