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. Will you be having your primary care at IMC? ☐ Yes ☐ Don't know yet
☐ No -- Who is your primary physician?_____

3. Do you have a Durable Power of Attorney for Health Care? ☐ No ☐ Yes: Who is it?_____

4 .Who lives with you in your home? _____

MEDICAL HISTORY

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? Are you under a doctors' care? Who?

☐ Cancer: Which type of cancer: ..... ☐ No ☐ Yes _____
☐ Heart Disease..... ☐ No ☐ Yes _____
☐ Diabetes..... ☐ No ☐ Yes _____
☐ High Blood Pressure..... ☐ No ☐ Yes _____
☐ Headaches..... ☐ No ☐ Yes _____
☐ Neurological conditions..... ☐ No ☐ Yes _____
☐ Kidney/urinary problems..... ☐ No ☐ Yes _____
☐ Stomach, GI, problems..... ☐ No ☐ Yes _____
☐ Depression..... ☐ No ☐ Yes _____
☐ Experienced violence or abuse..... ☐ No ☐ Yes, When:_____

☐ Other_____

Women: Number of Pregnancies _____ Live Births: _____ Living Children/ ages_____

Complications during pregnancy or delivery?_____

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

_____
_____
_____
_____

9. Known Allergies to Medications:_____

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10. Smoke: ◯ Never ◯ Stopped: _____ Years/Months Smoke Free ◯ Yes: _____ Years _____ packs/ day

11. How often do you consume alcohol:_____What Type:_____

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

_____
_____
_____
_____
_____
_____

13. What is/was your occupation?_____

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

☐ Heart disease, high blood pressure, stroke or diabetes
☐ Colon cancer ☐ Breast or Ovarian Cancer ☐ Melanoma skin cancer
☐ History of alcohol or drug addiction ☐ History of violence or abuse

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

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
Chinese Medicine			
Acupuncture			
Massage			
Chiropractic			
Nutrition			
Energy work			
Naturopathic Medicine			
Feldenkrais			
Tai Chi /Chi Gung			
Herbs, supplements			
Biofeedback			
Counseling/therapy			

_____

Other things we should know: