UCDAVIS
HEALTH

Welcome to UC Davis
Primary Care Integrative Medicine

You have scheduled an appointment with Integrative Medicine, and we are enclosing a number of forms for you to complete prior to your appointment.

This will assist us in working with you toward meeting your goals and developing a well-rounded plan to address your health concerns.

If you are already a patient at UC Davis, we have access to your medical information records and will review your medical history prior to your visit and will take that plus the information requested below to assist you during your visit.

Please bring any current medications or supplements (the actual containers) you are taking with you to your first visit.

If you are a new patient to our clinic, we ask that you arrive 20 minutes before your scheduled appointment time in order to fill out any necessary paperwork. If you are not able to arrive on time for your scheduled appointment, please call to let us know 24 hours in advance, so we may reschedule. Please arrive early for your appointment so that the necessary paperwork and intake procedures can be completed, and you can benefit from the full time of your appointment. We also request that you do not change the amount of time scheduled for your session.

The initial visit/ consultation is usually covered by most health plans, copays and deductibles may apply. Your provider may recommend procedures or treatments which may not be covered by your insurance, including acupuncture and osteopathic manipulations…etc.

Please check with your insurance prior to receiving theses additional procedures, and we will do our best to obtain authorization for services and inform you of any associated costs.

If you have any questions regarding your appointment, or regarding this letter, please feel free to contact us at UC Davis Integrative Health.

Thank you, we look forward to seeing you.

UC Davis Integrative Medicine Team.

UC Davis Primary Care Integrative Medicine Clinic

Name: ________________________________ **Date of birth:** ____________________________________

What are your goals for this visit?

____

____

____

____

Prioritize your most important health concerns today?

Concern *Example: Headache*	**Onset** *June 1978*	**Frequency** *4 times/Week*	**Severity** *mild/moderate/severe*
1.			
2.			
3.			
4.			
5.			
6.			

What prior experiences have you had with complementary medicine?

During the past year, have you used any complementary healing approaches? Please select all that apply.

- ☐ Guided imagery, Biofeedback, or Hypnosis
- ☐ Meditation
- ☐ Yoga, Tai Chi, or Qi gong
- ☐ Acupuncture
- ☐ Ayurveda
- ☐ Chiropractic or Osteopathic manipulation or Craniosacral therapy
- ☐ Homeopathy
- ☐ Massage
- ☐ Modified diet (e.g., gluten free, vegan, FODMAP)
- ☐ Movement techniques (e.g., Alexander technique, Feldenkrais)
- ☐ Naturopathy
- ☐ None of these

What do you live for? What matters to you? Why do you want to be healthy? Are there any areas you would like to work on? Where might you start? Write a few words to capture your thoughts:

____

____

____

REVIEW OF SYMPTOMS

Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE

0 = Never or almost never have the symptom 1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe 3 = Frequently have it, effect is not severe 4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total ________

EARS

___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total ________

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total ________

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total ________

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total ________

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total ________

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total ________

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total ________

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total ________

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total ________

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total ________

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation *Total*

____

SKIN

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total ________

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total ________

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total ________

GRAND TOTAL __________

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MEDICATIONS: ***Please bring all your medications and supplements with you to your visit.***

PRESCRIPTION MEDICATIONS - Please list on the table below ALL prescription medication you take or use.
(If you are a patient of UC Davis for your primary care you may leave this blank.)

Name of Medication (Brand name) and **Strength**	Label Directions for Use: **How were you told to take this medication?**	**How often** do you take/use this medication?	**How much** do you take/use for each dose?	**When did you begin taking** this medication? (Date: month/year)	**Why** (for what medical condition) are you taking/using this medication?	**When did you stop taking** this medication? (Date: month/year)	**Why** did you stop taking this medication?
Example:Zestril 20 mg	*One tablet daily*	*Once a day*	*One tablet*	*March, 1998*	*High blood pressure*	*Still taking it*	

NONPRESCRIPTION MEDICATIONS AND SUPPLEMENTS (Vitamins, Minerals, Herbs, Herbal products, Remedies, and Other health products) - Please list on the table below ALL nonprescription medications and supplements you take or use. *For products with many ingredients –use back of last page. Please bring supplement bottles to your appointment.

Brand name of Product and list of **Ingredients** (Please list each ingredient)	**Amount of each Ingredient** per tablet or teaspoonful	**How often** do you take/use this product?	**How much** do you take/use for each dose?	**When did you begin taking** this medication? (Date: month/year)	**Why** (Medical condition) are you taking or using this product?	**When did you stop taking** this product? (month/year)	**Why** did you stop taking this product?
Example: *Oscal 500 + D* *Calcium Vitamin D*	*500 mg* *125 IU*	*Twice a day*	*One tablet*	*January 2000*	*Bone protection*	*I am still taking it*	

Are you allergic to or have you had a "bad reaction" to any medication or other substance?

_____ Yes **_____ No**

⇩

If Yes, please list medication or substance and the reaction (what happened when you took it?):

Medication/Substance	**Reaction**

Please complete the list below about your family health history:
Please be sure to indicate immediate family diagnosed with the following:

Family Member	*Age*	*Medical Illnesses: please indicate if heart disease (in their 20s or 30s), melanoma, breast cancer, ovarian cancer, colon cancer*	*If deceased, cause and age at death*	*If deceased, your age at time of death*
Mother:				
Father:				
Brother(s):				
Sister(s):				

SOCIAL HISTORY

What education have you completed?
Current/past employment
With whom do you live?
Do you currently feel safe in your home?
Have you had or witnessed any violent/traumatic/abusive life experiences?
Have you traveled outside of the country in last year? YES/NO Where?
Do you have any pets? What kind?
What are your hobbies?
What brings you joy?
Please describe your history with tobacco, alcohol and any other drug use?

NUTRITION

In the last month, how many **times per day** did you eat the following: ***(Fill in ONE circle for each line)***

	NEVER/ RARELY	1-2 times per day	3-4 times per day	5+ times per day
a. Fruits and vegetables (not including fruit juice and potatoes)	○	○	○	○
b. Fatty foods and snacks (chips, french fries, fried foods)	○	○	○	○
c. Sugary foods and drinks (soda, fruit juice, lemonade, desserts, cookies, candy)	○	○	○	○
d. Whole grain breads, pasta, cereal and rice (not including white grains)	○	○	○	○
e. Red and processed meats (hamburgers, steak, bologna, bacon)	○	○	○	○
f. Dairy (milk, yogurt, cheese)	○	○	○	○
g. Lean meat (fish, seafoods, chicken, turkey, egg whites)	○	○	○	○
h. Alternative protein/carbohydrate sources (beans, nuts, seeds, hummus, soy foods)	○	○	○	○

What is your typical:
Breakfast? Do you eat breakfast? Yes/No
Lunch?
Dinner?
Snack?
How much water do you drink/day?
Are you on a special diet?
Do you avoid certain foods? Why?
Do you develop symptoms immediately after eating such as belching, bloating, and sneezing or hives?
Do you feel you have delayed symptoms (develop 24 hours or more later) after eating certain foods such as fatigue, muscle aches, sinus congestion, etc.?
How would you describe your relationship with food?

EXERCISE/MOVEMENT

How often do you exercise/move per week?
What types of exercise do you do?
What types of exercise/movement do you enjoy?
How do you feel after exercise?
Do you engage in any mindful movement (yoga, tai chi, etc.)?

Sleep Disturbance – Short Form 4a

Please respond to each question or statement by marking one box per row.

	In the past 7 days…	**Very poor**	**Poor**	**Fair**	**Good**	**Very good**
1	My sleep quality was	☐	☐	☐	☐	☐
	In the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
2	My sleep was refreshing.	☐	☐	☐	☐	☐
3	I had a problem with my sleep.................	☐	☐	☐	☐	☐
4	I had difficulty falling asleep	☐	☐	☐	☐	☐

How many hours of sleep on average do you get a night? (including naps): ______________

Fatigue – Short Form 4A

Please respond to each question or statement by marking one box per row.

	During the past 7 days…	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
1	I feel fatigued	☐	☐	☐	☐	☐
2	I have trouble starting things because I am tired...	☐	☐	☐	☐	☐
	In the past 7 days…					
3	How run-down did you feel on average? ...	☐	☐	☐	☐	☐
4	How fatigued were you on average?	☐	☐	☐	☐	☐

STRESS:

*In the past week, how much **stress** was present in your life?*

0……………………………………………………………………………………………..10

No Stress **Extreme Stress**

Biggest life challenges currently?
How do you manage your stress?
Does your stress level interfere with your enjoyment of life, your sleep or your relationships?

Emotional Distress-Depression – Short Form 4a

Please respond to each question or statement by marking one box per row.

	In the past 7 days...	Never	Rarely	Sometimes	Often	Always
1	I felt worthless	☐	☐	☐	☐	☐
2	I felt helpless	☐	☐	☐	☐	☐
3	I felt depressed	☐	☐	☐	☐	☐
4	I felt hopeless	☐	☐	☐	☐	☐

Emotional Distress-Anxiety – Short Form 4a

Please respond to each question or statement by marking one box per row.

	In the past 7 days…	Never	Rarely	Sometimes	Often	Always
1	I felt fearful..	☐	☐	☐	☐	☐
2	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
3	My worries overwhelmed me.....................	☐	☐	☐	☐	☐
4	I felt uneasy	☐	☐	☐	☐	☐

Emotional Distress - Anger – Short Form 5a

Please respond to each item by marking one box per row.

In the past 7 days...

		Never	Rarely	Sometimes	Often	Always
EDANG03	I was irritated more than people knew ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANG09	I felt angry	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANG15	I felt like I was ready to explode	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANG30	I was grouchy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANG35	I felt annoyed...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Interference – Short Form 4a

Please respond to each question or statement by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
1	How much did pain interfere with your day to day activities?................................	☐	☐	☐	☐	☐
2	How much did pain interfere with work around the home?....................................	☐	☐	☐	☐	☐
3	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4	How much did pain interfere with your household chores?..................................	☐	☐	☐	☐	☐

Physical Function – Short Form 4a

Please respond to each question or statement by marking one box per row.

		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
1	Are you able to do chores such as vacuuming or yard work?..........................	☐	☐	☐	☐	☐
2	Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Are you able to run errands and shop?.......	☐	☐	☐	☐	☐

SOCIAL SUPPORT: ABILITY TO PARTICIPATE IN SOCIAL ROLES AND ACTIVITIES

	Ability to Participate in Social Roles and Activities	Never	Rarely	Sometimes	Usually	Always
21	I have trouble doing all of my regular leisure activities with others	☐	☐	☐	☐	☐
22	I have trouble doing all of the family activities that I want to do	☐	☐	☐	☐	☐
23	I have trouble doing all of my usual work (include work at home)	☐	☐	☐	☐	☐
24	I have trouble doing all of the activities with friends that I want to do	☐	☐	☐	☐	☐

Emotional Support – Short Form 4a

Please respond to each item by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
FSE31053x2	I have someone who will listen to me when I need to talk..................................	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FSE31059x2	I have someone to confide in or talk to about myself or my problems	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SS12x	I have someone who makes me feel appreciated...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SSQ3x2	I have someone to talk with when I have a bad day	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Instrumental Support – Short Form 4a

Please respond to each item by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
CCC31052x	Do you have someone to help you if you are confined to bed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CCC31055x	Do you have someone to take you to the doctor if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
CCC31065x	Do you have someone to help with your daily chores if you are sick?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
SS6	Do you have someone to run errands if you need it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Social Isolation –Short Form 4a

Please respond to each item by marking one box per row.

		Never	Rarely	Sometimes	Usually	Always
UCLA11x2	I feel left out..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA13x3	I feel that people barely know me...........	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA14x2	I feel isolated from others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
UCLA18x2	I feel that people are around me but not with me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Who are the most important people in your life?
What groups/communities are you a part of?
Are any of your current relationships stressful for you?
Have you been involved in abusive relationships in your life
Did you feel safe growing up?
Was alcoholism or substance abuse present in your childhood home or in your current relationship?

ENVIRONMENT

Have you been exposed to any toxic metals at home or work?
Do you feel worse at certain times of year?

RELIGION/SPIRITUALITY

How important is religion/spirituality to you?
Is there a religious/spiritual tradition that you practice within and if so what?
Do you engage in prayer or meditation?