Medical Record Number

Patient Name

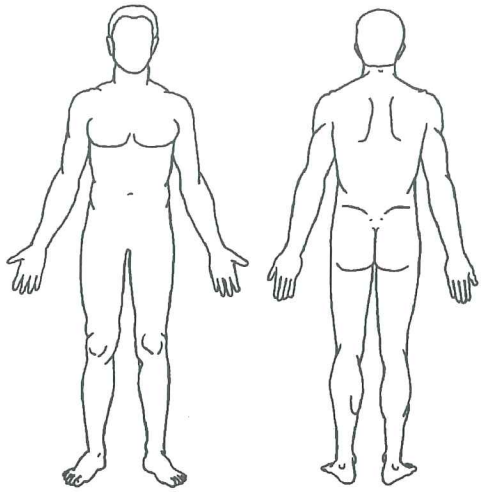
Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINICS • INTEGRATIVE MEDICINE
INTAKE FORM

Reason for visit:

Is pain or discomfort your problem? ❑ No (Skip to allergy box below) ❑ Yes (Please continue)



On the figure below, use P for pain location, N for numbness, S for spasm area.

What makes the pain better? _____

What makes the pain worse? _____

How long does the pain last? _____

How often do you feel it? _____

When did the pain start? _____

Put an 'X' on the Pain Severity Line *which ranges in value from 0 (no pain) to 10 (worst possible pain)*

0 1 2 3 4 5 6 7 8 9 10

no pain **moderate pain** **worst possible pain**

Allergies: ❑ None ❑ Latex ❑ Lotions ❑ Food _____
❑ Medications _____

Career: _____ **Working:** _____ hours per week

Current Activity Level: ❑ Active ❑ Moderate ❑ Light ❑ Sedentary, due to: _____

Diet: ❑ Regular ❑ for weight gain ❑ for weight reduction ❑ Special, namely _____

Tobacco: ❑ Never ❑ Smoking from age _____ to _____ at the rate of _____ packs per day

Alcohol: ❑ Never ❑ Estimated drinks per day currently _____

Drugs: ❑ Never ❑ Type, route and frequency _____

Living situation: ❑ Alone ❑ with others, circle: spouse children parents friends others _____

Sleeping: _____ hours per night with _____ awakenings

Religious or spiritual practices: ❑ No ❑ Yes, namely _____

Major stressors in your life in the past 2 to 3 years:

Complementary/integrative therapy already explored: ❑ Acupuncture ❑ Hypnosis
❑ Biofeedback ❑ Herbs ❑ Dietary supplements ❑ Guided imagery ❑ Meditation
❑ Yoga ❑ Other: _____

Which if any therapies were effective in helping you?

SYSTEM ISSUES Circle the sign(s) and symptom(s) that you are currently experiencing:

General: weight changes, weakness, fatigue, fever, night sweats

Cardiovascular: high blood pressure, murmur, trouble with exercising, pacemaker

Respiratory: coughing up mucus, blood, asthma, bronchitis, emphysema, pneumonia, TB, chest pain

Metabolic: thyroid, sweating, diabetes, thirst, hunger, excessive urination, growth, pigmentation, goiter, impotence

Neurological: fainting, blackouts, seizures, paralysis, weakness, numbness, tingling, headache, migraine, vertigo

Gastrointestinal: heartburn, nausea, vomiting, indigestion, change in bowel habits, constipation, diarrhea

Genitourinary: infections, frequency, urgency, hesitancy, incontinence, stones

Gynecological: pregnancy (# of weeks _____), PMS, breast lump, nipple discharge, sexual difficulty

Skin: rashes, lumps, itchy areas, dry, nail or hair changes

Musculoskeletal: joint pain, stiffness, arthritis, gout, neck stiffness

Eyes: glasses, contact lens, double vision, visual loss, mucous discharge

Ears, Nose & Throat: deafness, ringing, frequent colds, bloody nose, sinus infection, hoarseness, voice change

Circulation: anemia, bruising, bleeding, leg cramps, varicose veins, feelings of heat or cold

Psychological/Emotional: difficulty sleeping, altered appetite, hallucinations, depression, anxiety

Prescription Med	Reason for taking	Year Started	Dose/Frequency
Supplements, Vitamins, Herbs	**Reason for taking**	**Year Started**	**Dose/Frequency**

Major Illness/Surgery (medical & psychiatric)	Onset	Current status

Date: _____ **Completed by:** _____ **Relationship if other than patient:** _____