

Integrative Center for Healing

*Please be certain that this intake form is completed and returned to
Kimberly Zedalis, I-MD, Ph.D. at Integrative Center for Healing
1 week prior to your appointment date.*

New Client Intake Form

All information received on this form will be treated as strictly confidential. Please fill out the form **completely and accurately**. This information is essential to helping the doctor to develop a wellness program that addresses your needs, goals and interests and is safe and effective.

Appointment Date and Time: _____ Medical Record # _____

Have you ever been seen at ICFH before? Yes No (IF YES, include Medical Record # above.)

Demographics					
First Name		Middle Name		Last Name	
Date of Birth		Age		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address					
City, State, Zip code					
Preferred phone	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile				
Secondary phone	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile				
Email address					
Referred by					
Concerns					
What health and/or nutrition concerns would you like to focus on during your visit?					
1.					
2.					
3.					

Medical History					
Please check "yes" for the health conditions that your doctor has diagnosed, and then record the approximate date of onset.					
CONDITION	Yes	Date of Onset	CONDITION	Yes	Date of Onset
GASTROINTESTINAL			INFLAMMATORY / AUTOIMMUNE		
Irritable Bowel Syndrome	<input type="checkbox"/>		Chronic Fatigue Syndrome	<input type="checkbox"/>	
Inflammatory Bowel Disease	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	
Crohn's Disease	<input type="checkbox"/>		Lupus SLE	<input type="checkbox"/>	
Ulcerative Colitis	<input type="checkbox"/>		Frequent Infections	<input type="checkbox"/>	
Celiac Disease	<input type="checkbox"/>		Severe Infectious Disease	<input type="checkbox"/>	
Gastric or Peptic Ulcer Disease	<input type="checkbox"/>		Herpes	<input type="checkbox"/>	
GERD, reflux / heartburn	<input type="checkbox"/>		Gout	<input type="checkbox"/>	
Hepatitis C or Liver Disease	<input type="checkbox"/>		Other:	<input type="checkbox"/>	
Food Intolerance	<input type="checkbox"/>				
Other:	<input type="checkbox"/>				
RESPIRATORY			MUSCULOSKELETAL / PAIN		
Asthma	<input type="checkbox"/>		Osteoarthritis	<input type="checkbox"/>	
Chronic Sinusitis	<input type="checkbox"/>		Chronic pain	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>		Fibromyalgia	<input type="checkbox"/>	
Bronchitis or Emphysema	<input type="checkbox"/>		Migraines	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>		Other:	<input type="checkbox"/>	
Other:	<input type="checkbox"/>				
CARDIOVASCULAR			URINARY / REPRODUCTIVE		
Heart Disease / Heart Attack	<input type="checkbox"/>		Kidney Stones	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>		Urinary Tract Infections	<input type="checkbox"/>	
Elevated Cholesterol	<input type="checkbox"/>		Yeast Infection	<input type="checkbox"/>	
Irregular Heart Rate	<input type="checkbox"/>		Prostate Problem	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>		Other:	<input type="checkbox"/>	
Other:	<input type="checkbox"/>				
NEUROLOGICAL / BRAIN			METABOLIC / ENDOCRINE		
Depression	<input type="checkbox"/>		Type 1 Diabetes	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>		Type 2 Diabetes	<input type="checkbox"/>	
Bipolar disorder	<input type="checkbox"/>		Metabolic syndrome	<input type="checkbox"/>	
ADD/ADHD	<input type="checkbox"/>		Hypoglycemia	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>		Hypothyroidism	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>		Hyperthyroidism	<input type="checkbox"/>	
Anorexia Nervosa	<input type="checkbox"/>		Polycystic Ovarian Syndrome	<input type="checkbox"/>	
Bulimia	<input type="checkbox"/>		Infertility	<input type="checkbox"/>	
Unspecified Eating Disorder	<input type="checkbox"/>		Other:	<input type="checkbox"/>	
Parkinson's Disease	<input type="checkbox"/>				
Other:	<input type="checkbox"/>				
DERMATOLOGICAL			CANCER: Please list type(s) and treatments.		
Eczema	<input type="checkbox"/>				
Psoriasis	<input type="checkbox"/>				
Acne	<input type="checkbox"/>				
Other:	<input type="checkbox"/>				
Additional health conditions your doctor has diagnosed:					
Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known.					
Your Birth History: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section			Were you breastfed as an infant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Family History				
Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.				
Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	<input type="checkbox"/>			
High Blood Pressure	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>			
Overweight	<input type="checkbox"/>			
Food Intolerance	<input type="checkbox"/>			
Autoimmune Disease	<input type="checkbox"/>			
Oral History				
Do you visit a dentist twice per year? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any silver/mercury amalgam fillings? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?				
Allergies			Allergic Symptoms Experienced	
Food				
Medication				
Supplement				
Environmental				
Medications and Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.				
Medication Name	Year Started	Dose	Frequency	Reason
Herb/Supplement	Year Started	Dose	Frequency	Reason
Have you had prolonged or regular use of NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you had prolonged or regular use of Tylenol? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you taken antibiotics > 3 times per year? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Have you been on antibiotics long term (> 1 month continuously)? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Lifestyle Information

Do you engage in physical activity on a regular basis? Yes No If yes, complete the table below

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknights? < 6 6-8 8-10 10 +

How many hours do you sleep on weekends? < 6 6-8 8-10 10 +

Check which apply to you: Trouble falling asleep Wake up during the night Don't feel rested

How do you handle stress? What helps you relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following?

Cigarette smoke Paint fumes Perfumes Nail Polish
 Auto exhaust / fumes Chemicals Dry-cleaned clothes Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? Yes No
If yes, please explain.

Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals.

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? Yes No

Have you changed your eating habits for a health reason? Yes No Please describe.

Are you currently following a particular diet or nutrition plan? Yes No Please describe.

Do you avoid any particular foods? Yes No

Please explain.

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Buttermilk Biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pretzels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Popcorn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Snack Food (crackers, Goldfish)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pastries, cookies, cakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juice- Indicate type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punch, Lemonade, or Sweet Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soda (not diet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea (white, green, black)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Daily Intake Summary

What type(s) of protein do you consume most days of the week? (Check all that apply.)

Animal meat Beans Eggs Soy-based Dairy Nuts and seeds

How many servings of fruit do you have in a day?

How many servings of vegetables do you have in a day?

Provide an estimate of the amount of each beverage that you consume on an average day.
Circle the label that is most appropriate based on how you consume the beverage.

Water: ___ ounces, cup(s)

Diet soda: ___ cup(s), can(s), liter(s)

Tea: ___ cup(s)

Coffee: ___ ounces, cup(s)

Non-diet soda: ___ cup(s), can(s), liter(s)

Other: _____

SYMPTOM SURVEY

Client Name: _____ Date: _____

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score every symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

<p>SCALE OF SYMPTOM POINTS: 0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe</p>	<p>Grand Total:</p>
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CONSTITUTIONAL

- ___ Fatigue (sluggish, tired)
- ___ Hyperactive (nervous energy)
- ___ Restless (can't relax/sit still)
- ___ Sleepiness During Day
- ___ Insomnia at Night
- ___ Malaise
- ___ TOTAL (0-20)

EMOTIONAL/MENTAL

- ___ Depression (feelings of hopelessness)
- ___ Anxiety (vague fears, uneasiness)
- ___ Mood Swings (rapid distinct changes)
- ___ Irritability
- ___ Forgetfulness
- ___ Lack of concentration/focus
- ___ TOTAL (0-24)

HEAD/EARS

- ___ Headache (any kind)
- ___ Migraine (diagnosed)
- ___ Earache
- ___ Ear Infection
- ___ Ringing in Ear
- ___ Itchy Ears
- ___ TOTAL (0-24)

SKIN

- ___ Blemishes, Acne
- ___ Rashes, Hives
- ___ Eczema
- ___ "Rosy" Cheeks
- ___ TOTAL (0-16)

NASAL/SINUS

- ___ Post Nasal Drip
- ___ Sinus Pain
- ___ Runny Nose
- ___ Stuffy Nose
- ___ Sneezing
- ___ TOTAL (0-20)

MOUTH/THROAT

- ___ Sore Throat
- ___ Swollen Throat
- ___ Swelling of Lips/Tongue
- ___ Gagging/Throat Clearing
- ___ Lesions ("Canker Sores")
- ___ TOTAL (0-20)

LUNGS

- ___ Wheezing" (Asthma or Asthma-like Symptoms)
- ___ Chest Congestion
- ___ Non-Productive Coughing
- ___ Productive Coughing
- ___ TOTAL (0-20)

EYES

- ___ Red or Swollen Eyes
- ___ Watery Eyes
- ___ Itchy Eyes
- ___ Dark Circles" or "Baggy"
- ___ TOTAL (0-16)

GENITOURINARY

- ___ Increased Urinary Frequency
- ___ Painful Urination
- ___ TOTAL (0-8)

MUSCULOSKELETAL

- ___ Joint Pains/Aching
- ___ Stiff Joints
- ___ Muscle Aches
- ___ Stiff Muscles
- ___ TOTAL (0-20)

CARDIOVASCULAR

- ___ Irregular Heartbeat
- ___ High Blood Pressure ___
- ___ TOTAL (0-8)

DIGESTIVE

- ___ Heartburn/Esoph.Reflux
- ___ Stomach Pains/Cramps
- ___ Intestinal Pains/Cramps
- ___ Constipation
- ___ Diarrhea
- ___ Bloating Sensation
- ___ Gas (of Any Kind)
- ___ Nausea, Vomiting
- ___ Painful Elimination
- ___ TOTAL (0-36)

WEIGHT MANAGEMENT

- ___ Record Actual Weight
- ___ Approximate Height
- ___ Fluctuating Weight
- ___ Food Cravings
- ___ Water Retention
- ___ Binge Eating or Drinking
- ___ Purging (all methods)
- ___ TOTAL (0-20)

Comments: