Integrative Medicine of Pueblo
200 W B St Ste 110
Pueblo, CO - 81003

IM Intake

First Name _____

Last Name _____

DOB _____

Current Concerns & Goal

What is brining you in for an integrative medicine consult?

What are your top 1-3 goals of working with Dr. Patrick?

Prior Treatments

Have you taken any medication, either in the past or currently, for your current complaint? If yes, please describe.

Have you taken any supplements, either in the past or currently, for your current complaint? If yes, please describe.

Have you changed your diet, either in the past or currently, for your current complaint? If yes, please describe.

Have you modified your activities, either in the past or currently, for your current complaint? If yes, please describe.

Have you done any other treatments, either in the past or currently, for your current complaint? If yes, please describe.

Lifestyle Intake

Past Medical History

Nutrition

You will be receiving a 7 day diet diary as a seperate form. Please do your best to complete this diary for Dr. Patrick prior to your initial visit. It is also important for you to eat as you normally would during this time period for her to get an accurate assessment of your health.

How would you describe the quality of your diet?

☐ Poor ☐ Fair ☐ Good ☐ Excellent
☐ Other _____

Comments _____

How would you describe your relationship with food?

Do you have any food allergies or intolerances? If yes, please list and describe reaction when you consume them.

☐ Yes ☐ No

Comments _____

Do you follow any particular dietary pattern? (Mediterranean, Paleo, Keto, Weight Watchers, etc)

How many servings a fruits and vegetables do you get per day on average?

☐ Less than 1 ☐ 1-2 ☐ 3-4 ☐ 5 or more

How many times do you eat out per week?

☐ 0-1 ☐ 1-2 ☐ 2-3 ☐ 4-5 ☐ 6+

Comments _____

Besides water, what fluids do you drink on a regular (weekly) basis? Please describe the amounts in comments.

☐ Alcohol ☐ Coffee ☐ Energy drinks ☐ Soda
☐ Sweet Tea ☐ Unsweetened Tea
☐ Other _____

Comments _____

Do you suffer from any of the following gastrointestinal symptoms on a regular basis?

☐ Acid reflux ☐ Bloating ☐ Constipation ☐ Cramping
☐ Diarrhea ☐ Excess gas
☐ Other _____

Comments _____

Were you breastfed as a baby?

☐ Yes ☐ No ☐ Unsure

Movement

How would you describe your lifestyle in terms of movement?

☐ Sedentary (I am sitting most of the day)
☐ Moderate (I sit, stand and walk fairly equally throughout the day)
☐ Active (I am on my feet most of the day)
☐ Other _____

Comments _____

How much exercise do you get in an average week?

☐ 0 hours ☐ 1-2 hours ☐ 3-4 hours ☐ 4-5 hours
☐ >6 hours
☐ Other _____

Comments _____

What types of physical activity do you perform?

☐ None ☐ Aerobics ☐ Biking ☐ Dancing
☐ Gardening ☐ Hiking ☐ HIIT ☐ Pilates ☐ Running
☐ Swimming/Aquatics ☐ Yoga ☐ Walking ☐ Weight lifting
☐ Other _____

Comments _____

Do you have any barriers to physical activity?

☐ Energy ☐ Pain ☐ Time
☐ Other _____

Comments _____

Is there anything else you would like me to know about your physical activity?

Sleep

How many hours do you spend each night IN BED on average?

☐ Less than 4 ☐ 4-5 ☐ 5-6 ☐ 6-7 ☐ 7-8
☐ More than 8

Comments _____

How many hours do you spend each night ASLEEP on average?

☐ Less than 4 ☐ 4-5 ☐ 5-6 ☐ 6-7 ☐ 7-8
☐ More than 8

Comments _____

How would you rate your sleep quality? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Comments _____

Do you take any medications or supplements to help you sleep at night? If yes, what do you take? ☐ Yes ☐ No

Comments _____

Do you suffer from any medical conditions that negatively affect your sleep? ☐ None ☐ Anxiety ☐ Depression ☐ Prostate problems, frequent urination ☐ Restless leg syndrome ☐ Sleep apnea ☐ Other _____

Comments _____

Other Lifestyle Factors

Do you feel you have an excessive amount of stress in your life? If yes, please list your stressors. ☐ Yes ☐ No

Comments _____

What are some healthy ways you manage stress?

List some of the possible unhealthy ways you are managing stress.

Describe your relationships to those you are closest to in your life (pick 1-3 people).

What do you do for leisure, rest and relaxation?

How many hours of TV do you watch per day on average? ☐ Less than 1 ☐ 1-2 ☐ More than 2

Comments _____

How many hours do you spend on social media per day on average? ☐ Less than 1 ☐ 1-2 ☐ More than 2

Comments _____

Do you consider yourself a spiritual person? If yes, please describe. ☐ Yes ☐ No

Comments _____

What would you say your purpose in life is?

Review of Systems

Review of Systems

Please Check Positives Only

General

☐ Fever ☐ Chills ☐ Fatigue ☐ Weight gain
☐ Weight loss ☐ Excessive Sweating ☐ Weakness
☐ Night sweats
☐ Other _____

Head

☐ Head Trauma history ☐ Headache ☐ Migraine
☐ Hair loss
☐ Other _____

Ears, Nose, Mouth and Throat

☐ Hearing loss ☐ Tinnitus (ringing in the ears)
☐ Ear discharge ☐ Ear pain ☐ Excessive earwax
☐ Nasal discharge ☐ Post nasal drip
☐ Nasal or sinus congestion ☐ Sinus pain ☐ Sneezing
☐ Nose bleeds ☐ Loss of Taste ☐ Loss of Smell
☐ Gum/Dental Problems ☐ Hoarseness ☐ Sore throat
☐ Swollen neck ☐ Mouth sores
☐ Difficulty/pain on swallowing ☐ Bad Breath
☐ Jaw/TMJ Problems
☐ Other _____

Eyes

☐ Corrective lenses (glasses/contacts) ☐ Dry eyes
☐ Eye Redness ☐ Glaucoma ☐ Blurred vision
☐ Double Vision ☐ Itchy eyes ☐ Vision loss
☐ Eye Discharge ☐ Cataracts
☐ Other _____

Cardiac

☐ High blood pressure ☐ Low blood pressure
☐ Angina/Chest pain ☐ Palpitations ☐ Stroke
☐ Shortness of breath lying down ☐ Cold hands/feet
☐ Other _____

Respiratory

☐ Asthma ☐ Shortness of breath ☐ Wheezing ☐ Cough
☐ Sputum/Phlegm ☐ Coughing up blood ☐ Pain on breathing
☐ Other _____

Gastrointestinal

☐ Appetite Change ☐ Nausea ☐ Vomiting ☐ Indigestion
☐ Constipation ☐ Diarrhea ☐ Food intolerance
☐ Abdominal pain ☐ Hemorrhoids ☐ Heartburn
☐ Excessive Gas/bloating ☐ Rectal bleeding ☐ Rectal Itching
☐ Blood in stool ☐ Black Tarry stool
☐ Other _____

Urinary

☐ Frequent urination ☐ Incontinence ☐ Kidney stone history
☐ Blood in urine ☐ Pain with urination ☐ Waking to urinate
☐ Urinary urgency ☐ Flank pain ☐ Frequent urinary infections
☐ Other _____

Musculoskeletal

☐ Muscle aches ☐ Muscle spasms ☐ Muscle weakness
☐ Joint stiffness ☐ Joint pain ☐ Neck pain ☐ Back pain
☐ Other _____

Skin/Hair

☐ Acne ☐ Hives ☐ Eczema ☐ Dry skin ☐ Itchy skin
☐ Rash ☐ Rosacea ☐ Warts ☐ Skin color changes
☐ Hair loss ☐ Hair Thinning ☐ Dandruff ☐ Nail changes
☐ Other _____

Neurological

☐ Loss of sensation/Numbness ☐ Tingling ☐ Tremors
☐ Weakness ☐ Fainting ☐ Dizziness ☐ Seizures
☐ Loss of memory ☐ Brain fog ☐ Paralysis

☐ Other _____

Mental/Emotional

☐ Anger/irritability ☐ Fear/panic ☐ Anxiety
☐ Tension/stress ☐ Depression ☐ Suicidal thoughts
☐ Substance abuse ☐ Insomnia or difficulty sleeping
☐ Mood swings
☐ Other _____

Endocrine

☐ Heat Intolerance ☐ Cold Intolerance ☐ Thyroid Problems
☐ Excessive Thirst ☐ Excessive Hunger
☐ Other _____

Hematological/Immune/Lymphatic

☐ Easy Bleeding/Bruising ☐ Allergies ☐ Frequent Infections
☐ Swollen Glands ☐ Breast Pain/Tenderness ☐ Breast Lumps
☐ Nipple Discharge
☐ Other _____

Female Reproductive

☐ Irregular Cycles ☐ Bleeding or Spotting in between Menses
☐ Excessive Bleeding ☐ Pain during Intercourse
☐ PMS Symptoms (emotional and/or physical symptoms around the time of menses)
☐ Vaginal Itching or Dryness ☐ Vaginal Discharge
☐ Sexual Difficulties
☐ Other _____

Male Reproductive

☐ Hernia ☐ Testicular Mass ☐ Testicular Pain
☐ Sexual Difficulties
☐ Penile Symptoms (specify in the "others" section below)
☐ Waking at night to urinate ☐ Change in urine stream/flow
☐ Other _____