ARIA INTEGRATIVE MEDICINE
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Patient Health Information Form

Last Name: _____ First Name: _____

Nickname: _____ Birthdate: _____/_____/_____ Sex (specify): _____

Please complete this questionnaire as thoroughly as possible **before your 1st visit**. This will help us to better assist you in treatment for your condition. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so.

PRESENT HEALTH CONCERNS	
Please list the most important health concerns in order of significance	**Prior diagnosis of this problem (if one has been made)**
1.	1.
2.	2.
3.	3.
4.	4.

Whom may we thank for referring you today? _____

Do you have another primary care provider? _____

What three expectations do you have from this visit at our clinic?

1. _____
2. _____
3. _____

What long-term expectations do you have from working with our clinic?

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

Where would you say your health is currently? (Check One)

1 2 3 4 5 6 7 8 9 10

Extremely Poor Extremely Well

MEDICATIONS AND SUPPLEMENTS		
Please list the **medications** that you are currently taking with dosages and who prescribed them:		
Medication (Name)	**Dosage (amount, time(s) per day)**	**Prescriber (Doctor name/self)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
**If you need additional room, please attach an updated medication list to this form*		
Please list all the **supplements** that you are currently taking with dosages and who prescribed them:		
Supplement (Brand, Name)	**Dosage (amount, time(s) per day)**	**Prescriber (Doctor name/self)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
**If you need additional room, please attach an updated supplement list to this form*		

ALLERGIES

Do you have any LIFE-THREATENING allergies to medications or anything else? □ Yes □ No

If Yes, please explain: _____

_____

Do you have any NON Life-threatening allergies or medications or anything else? □ Yes □ No

If Yes, please explain: _____

_____

SOCIAL HISTORY

Do you use any of the following substances regularly? How often?

□ Tobacco _____

□ Alcohol _____

□ Coffee/Black Tea/Cola _____

□ Recreational Drugs _____

Do you follow any diet regimens or restrictions (Vegetarian, Vegan, Gluten Free…etc.)? □ Yes □ No

If Yes, please describe: _____

Please list a typical daily diet (breakfast, lunch, dinner, snacks, desserts)
B: _____

L: _____

D: _____

How much water do you drink per day? _____

Do you exercise regularly? □ Yes □ No How often? _____

What Type? _____

How Long? _____

Do you have any problems with your sleep? If so, please describe.

_____

_____

Average number of hours of sleep: _____

Rate your current energy on a scale of 1-10 (10 = highest): _____

Rate your current stress level on a scale of 1-10 (10 = highest): _____

What do you do to manage your stress? _____

Have you intentionally harmed yourself? _____

Have you ever seriously thought about hurting yourself? _____

Have you seriously thought about hurting others? _____

Do you feel you have an adequate support system? _____

Are you currently seeing a counselor? _____ If so, who? _____

In the past 2 weeks have you had little interest or pleasure in doing things? (circle one) YES NO

In the past 2 weeks have you been feeling down, depressed or hopeless? (circle one) YES NO

PAST MEDICAL HISTORY	
Have you had any of the following:	
Hospitalizations:	**What Month/Year:**
1.	
2.	
3.	
4.	
5.	
Serious Illness/Injury:	**What Month/Year:**
1.	
2.	
3.	
4.	
5.	

Date of last physical exam: _____

What exams were done at that time? _____

_____

Date of last blood tests: _____

What tests were done at that time? _____

_____

Women Only

Have you had an abnormal PAP? _____

If so, when was your last abnormal PAP, and have you had another PAP since then? _____

Do you have any problems with your menses? If so, please explain.

_____

Number of Pregnancies: _____ Number of live births: _____

Do you have problems with urination? If so, please explain. _____

Do you have any menopausal symptoms you are concerned about (hot flashes, etc.)? If so, please explain.

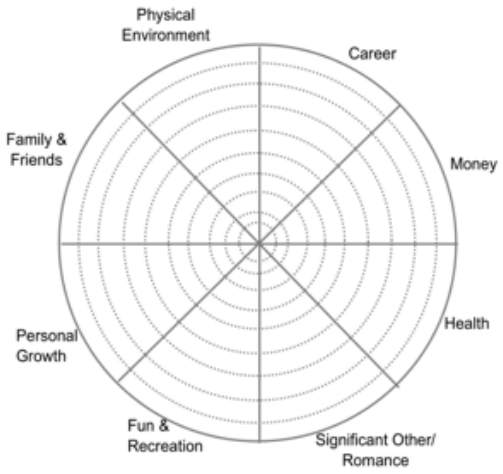
_____

PERSONAL AND FAMILY HISTORY			
If any of the following conditions applies **to you** or one of your **immediate** family members (parents, siblings, grandparents), please note the person associated with the condition, what year the condition took place and whether or not the condition is current.			
Condition	**Person Affected (Self, Parent… etc.)**	**Year**	**Current?**
Addiction (including alcoholism)			
Allergies (specify)			
Anemia			
Arthritis (specify)			
Asthma			
Cancer (specify)			
Celiac Disease			
Crohn's Disease			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Disease (specify)			
Hepatitis			
High Blood Pressure			
Kidney Disease (specify)			
Lupus (specify)			
Mental Illness (specify)			
Multiple Sclerosis			
STD (specify)			
Stroke			
Thyroid Disorder (specify)			
Tuberculosis			
Ulcerative Colitis			
Other			

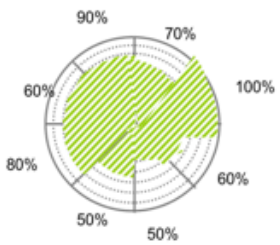
What is your marital Status? (Circle One) ☐ Single ☐ Married ☐ Significant Other

Are you currently employed? □ Yes □ No If yes, then where? _____

How long have you been employed here? _____ Do you enjoy your work? _____



Example:



Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

What do you LOVE to do? What are your passions?

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (please list)

_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

What do you want to be focusing on cultivating in yourself now?

_____