

## The University of Vermont College of Nursing and Health Sciences Practice Group

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Integrative Medicine- New Patient Intake Form  Dos: MRN:  Date:  Name: Date of Birth:  The reason for my visit is:  Do you have any prior experience with Complementary or Alternative Medicine?  If so, please describe.  What is your usual stress level on a scale of 0 (no stress) to 10 (maximum stress)?  No stress 0 1 2 3 4 5 6 7 8 9 10 Maximum stress  Do you have any of the following? (Please check all that apply)  Fatigue, lack of energy Headaches Shortness of Breath irritability  Trouble Falling Asleep Lighheadedness Frequent Colds/Flu Anxiety/Worry  Trouble Staying Asleep Muscle Aches Eczema Depression/Sadness  Nausea or Heartburn Joint Pain Asthma Lack of Interest  Gas/Bloating (after meals) Back Pain Environmental Allergies Loss of Libido  Loose Bowel Movements Chest Pain Difficulty Focusing/Memory Cold Hands/Feet			Office Use Only	
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Constipation Palpitations Hot Flashes/Night Sweats Feel Hot	Constination	Palnitations	Hot Flashes/Night Sweats	Feel Hot



## The University of Vermont College of Nursing and Health Sciences Practice Group

How would you best describe your diet? (Please check all that apply)				
Meat & Potatoes	Unhealthy Snacks	Lean ProteinsProcessed Foods		
		,		
Vegan/Vegetarian	Healthy Snacks	I always have starch with my meal		
l eat lots of fruits/vegeta	hles	I drinkcups of caffeinated coffee per day		
i ear iots of maits/vegeta	bics	cups of carteriated coffee per day		
! eat fish at least twice per week		l drinkcups of decaf coffee per day		
	·			
I drink tea (what kind?)_		I have something sweet days per week		
1 hava alaahalia haye	vragos por wook	I drink glasses of water per day		
1 have alcoholic beve	erages per week	I drinkglasses of water per day		
How would you describe yo	our exercise routine?			
	-			
What do you do to relax? [	o you have a regular rela	ixation practice?		
Please list ALL CURRENT SU	IPPLEMENTS including he	rbal medicines (brand and dosing)		
1.		8.		
2.	•	9.		
3.		10.		
4.		11.		
5.		12.		
6.		13.		
7		14.		
What is your usual sleep so	hedule?			
What time do you go to sle	ep?			
What time do you wake up	?			
Is your sleep restorative?	Yes / No			
Is there any other informat	tion you would like to sha	re before your visit?		
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