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

Integrative Medicine- New Patient Intake Form

Office Use Only	
DOS:	MRN:

Please print clearly

Name:	Date of Birth:

Date:

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
__Constipation	__Palpitations	__Hot Flashes/Night Sweats	__Feel Hot

APPLETREE BAY PRIMARY CARE
1205 NORTH AVENUE
BURLINGTON, VERMONT 05408
802-863-1313 • FAX 802-863-2396

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How would you best describe your diet? (Please check all that apply)			
__Meat & Potatoes	__Unhealthy Snacks	__Lean Proteins	__Processed Foods
__Vegan/Vegetarian	__Healthy Snacks	__I **always** have starch with my meal	
__I eat lots of fruits/vegetables		__I drink ____cups of caffeinated coffee per day	
__I eat fish at least twice per week		__I drink____cups of decaf coffee per day	
__ I drink tea (what kind?)_____		__I have something sweet ___ days per week	
__I have ___ alcoholic beverages per week		__I drink ___glasses of water per day	

How would you describe your exercise routine?

What do you do to relax? Do you have a regular relaxation practice?

Please list ALL CURRENT SUPPLEMENTS including herbal medicines (brand and dosing)

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

What is your usual sleep schedule?

What time do you go to sleep? _____

What time do you wake up? _____

Is your sleep restorative? Yes / No

Is there any other information you would like to share before your visit?

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