Hartford Hospital
A Hartford HealthCare Partner

573155

# Center for Healing Arts

*The Integrative Medicine Specialty Practice*

Name _____ Date of Birth _____Email_____ Date _____

Address _____Phone_____ Cell_____

Insurance Carrier _____ Policy Holder_____ Policy Number_____

Who referred you/how did you hear about us? _____

Please describe your previous experiences or interest in complementary or alternative medicine (e.g. acupuncture, hypnotherapy, massage therapy, naturopathy Reiki, etc.)_____

_____

What are your goals and expectations for your care and specific concerns would you like to address during your visit(s)?

_____

| Concern | Onset | Frequency | How this impacts your life |
|---|---|---|---|
| 1. _____ | _____ | _____ | _____ |
| 2. _____ | _____ | _____ | _____ |
| 3. _____ | _____ | _____ | _____ |

ALLERGIES (Medication or Food) _____

MIND/BODY

With whom do you live? _____

What pets do you live with? _____

Do you feel safe in your home? _____

What is your occupation? _____

Are you, or were you, married or partnered? _____

What are the ages of your children? _____

Who are the most important people in your life? _____

Do you participate in a spiritual or religious practice or have an active stress management or exercise program? _____

_____

Other items of concern or interest:_____

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**PERSONAL MEDICAL HISTORY:** Please list any surgical procedures/operations/major injuries:

_____

_____

_____

Please check the following conditions that apply to you and appropriate choices when given.

- ☐ Alcoholism or Substance Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clots
- ☐ Cancer (Type _____)
- ☐ Chemotherapy
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive (Crohn's, IBS, Ulcerative Colitis)
- ☐ Easy Bleeding
- ☐ Fibromyalgia
- ☐ Frequent Sinusitis
- ☐ Gall Bladder Problems
- ☐ GERD
- ☐ Hay Fever, Allergies, Eczema
- ☐ Hepatitis
- ☐ Heart Attack, Heart Disease, Heart Failure
- ☐ Heart Murmur
- ☐ Headaches (Migraines, Tension)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Infertility
- ☐ Kidney Infections/Stones
- ☐ Pneumonia
- ☐ Organ Transplant
- ☐ Rheumatic Fever
- ☐ Seizures, Epilepsy
- ☐ Serious Injury/Accident (Type _____)
- ☐ Sexually Transmitted Disease (Chlamydia, Warts, Herpes) (Specify Other _____)
- ☐ Skin Disease
- ☐ Stroke
- ☐ Thyroid Disease (Specify _____)
- ☐ Tuberculosis (TB)
- ☐ Urinary Problems (Incontinence, Infections)
- ☐ Vision Problems
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Transgender

***WOMEN ONLY:***

**Reproductive History**

Age at first menstrual period _____
Date of last menstrual period _____
Usual Flow: _____ Heavy _____ Moderate _____ Light
Length of period in days _____
Number of days between periods _____
Do you have: ☐Painful Periods ☐ Missed Periods,
☐Spotting between Periods ☐Vaginal Bleeding,
☐Unusual Discharge/Infections ☐ Recurrent Vaginal Infections

**Contraceptive History** (Please check)

Birth Control Pills Type _____ Duration _____
Diaphragm/Cap Type _____ Size _____
IUD Type _____ Last Change ___
☐Norplant ☐ Condom and/or ☐Foam, ☐Suppository
☐Tubal Ligation, ☐Hysterectomy, Partner Vasectomy
Other_____
Problems with current method_____

If you have gone through menopause, have you had any post-menopausal bleeding? _____
Date of last Pap smear _____
History of Abnormal Pap smears? _____
Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

***MEN ONLY:***

Do you have:
- ☐ Prostate Problems
- ☐ Vasectomy
- ☐ Difficulty starting or stopping urination
- ☐ Change in Sexual Function (libido, energy, erections?)
- ☐ Testicular Cancer
- ☐ Painful urination or erection

Other concerns to discuss:_____

**REVIEW OF SYSTEMS**: Please check any of the following symptoms that apply to you.

| | | | |
|---|---|---|---|
| General | | Muscles/Bones/Joints | |
| Fatigue | | Muscle pain | |
| Difficulty sleeping | | Muscle cramps or spasms | |
| Weight loss or weight gain | | Joint pain/stiffness/swelling | |
| Eyes/Ears/Nose/Throat/Sinuses | | Low back pain | |
| Blurred vision | | Neck pain | |
| Hearing loss or ringing in ears | | Other: | |
| Frequent infections | | Nervous System | |
| Jaw pain/TMJ | | Headaches | |
| Frequent throat clearing or post-nasal drainage | | Dizziness | |
| Heart/Circulation | | Balance problems | |
| Chest discomfort (pain/pressure/tightness) | | Weakness/Numbness/tingling | |
| Palpitations | | Difficulty concentrating | |
| Leg swelling | | Memory problems | |
| Lungs | | Allergies/Immune System | |
| Shortness of breath | | Seasonal allergies | |
| Wheezing | | Food allergies | |
| Cough | | Fever | |
| Coughing up blood | | Other: | |
| Digestion/Elimination | | Hormonal/Endocrine | |
| Heartburn/Reflux | | Cold or heat intolerance | |
| Nausea/Vomiting | | Night sweats | |
| Abdominal bloating | | Excessive thirst | |
| Abdominal pain/cramping | | Excessive hunger | |
| Excessive belching or gas | | Blood | |
| Constipation | | Easy bruising | |
| Diarrhea | | Abnormal bleeding | |
| Kidneys/Bladder/Urination | | Skin | |
| Urgency or increased frequency | | Rashes | |
| Pain or burning with urination | | Eczema | |
| Difficulty urinating | | Psychiatric/Psychological | |
| Blood in the urine | | Depression | |
| Leakage | | Anxiety or panic attacks | |
| Frequent infections | | Suicidal thoughts | |

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## FAMILY MEDICAL HISTORY:

| | | List family members who have or had this illness. |
|---|---|---|
| Arthritis | | |
| Alcoholism or Substance Abuse | | |
| Cancer: Breast | | |
| Cancer: Colon | | |
| Cancer: Other | | |
| Depression or other Mental illness | | |
| Diabetes | | |
| Glaucoma | | |
| High Blood Pressure | | |
| Heart Disease | | |
| High Cholesterol | | |
| Kidney Disease | | |
| Liver Disease (Hepatitis, etc) | | |
| Lung Disease (Asthma, COPD, etc.) | | |
| Stoke | | |
| Thyroid Disease | | |
| Other: | | |
| Other: | | |
| Other: | | |

## LIFESTYLE/BEHAVIOR

What are the major stressors in your life? _____

_____

How do you relax/relieve stress? _____

_____

What physical activity do you participate in? How often? _____

_____

What leisure activities/hobbies do you enjoy? _____

Do you have a spiritual or religious practice? _____

What brings meaning to your life? _____

Describe your sleep patterns. _____

Describe your overall energy level. _____

| | Amount Per Day | Amount Per Week | Never Used |
|---|---|---|---|
| **Tobacco** Cigarettes/cigars/pipe | _____ | _____ | _____ |
| **Alcohol** | _____ | _____ | _____ |
| **Recreational Drugs** | _____ | _____ | _____ |

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**DIET and NUTRITION:**

How would you currently rate your healthy eating habits: Poor ☐ Fair ☐ OK ☐ Good ☐ Great ☐

In the last 24-48 hours, what have you eaten for meals, snacks, beverages and condiments?

Breakfast: _____ 48 _____

Lunch: _____ 48 _____

Dinner: _____ 48 _____

Snacks: _____ 48 _____

How many meals do you eat per day? _____
Who does the food shopping in your home? _____
Who prepares the food in your home? _____
How often do you cook? _____
Which meals do you regularly eat outside your home? _____
Are you currently on a special diet? _____
Do you have any sensitivities to food or avoid any foods? _____
_____
How often to you eat fast food? _____
Which foods do you regularly crave? _____
What and how much do you drink on a typical day? _____ water _____ caffeine _____ other
How would you describe your relationship with food? _____
_____

**MEDICATIONS:** What medications are you currently taking? (Include prescription drugs and over the counter drugs.)

| Medication | Dose | Reason for Use | When Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What vitamins/minerals/herbal supplements are you currently taking?

| Brand or Other Name | Dose | Reason for Use | When Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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## QUESTIONNAIRE for Acupuncture/Energy/ Massage/Reiki

Have you ever had any of the following? ☐ Massage ☐ Energy healing ☐ Acupuncture ☐ Hypnosis
Do you have difficulty lying on your front, side or back? ☐ Yes ☐ No

Are you allergic to oils, lotions, ointment, liniments, or other substances put on your skin? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Have you had any significant dental work performed? ☐ Yes _____(include date and type) ☐ No

For women: Are you pregnant ☐ Yes ☐ No If yes, how many months? _____

What is your major concern today, for which you seek this treatment? _____
_____

When did you first notice this issue and what brought it on? _____

What aggravates the condition? _____

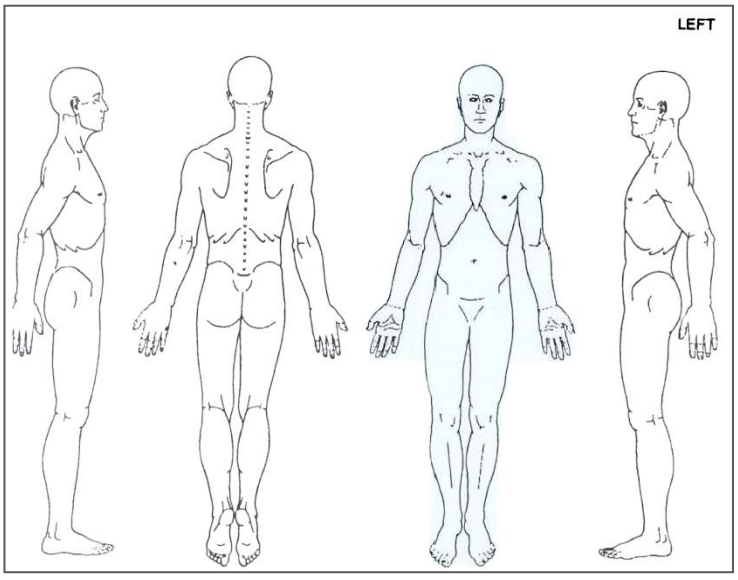
How does this condition impact your daily activities (sleep, work, sex, etc.)? _____

What have you done to get relief? _____

On a scale of 0 to 10 (10 being excruciating), please rate the degree of severity of your main complaint now _____

On a scale of 0 to 10, please rate the degree of severity of your problem within the past week _____

What are your expectations for this visit? _____




**Indicate painful or distressed areas:**

## CONSENT FORM FOR TREATMENT

Patient Signature: _____

Date _____ Time _____

Clinician Signature: _____

Date _____ Time _____