



Integrative Rheumatology Associates, P.C.

Integrative Medicine Health History

Name: _____ DOB: _____ Today's Date _____

Age: _____ Height: _____ Weight: _____ BMI _____

Name of primary care doctor: _____

What are your health goals? Concerns? _____

Medical History (specify year diagnosed): _____

Surgical History (specify year of surgery/procedure): _____

Medications (name, dose, frequency, start date): _____

Vitamins/Supplements/Herbs (name, brand, dose, frequency, manufacturer): _____

Drug or food allergies (specific reaction): _____



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Family History (immediate family/siblings): _____

Social History:

Married/Single/Divorced/Widowed _____

Children? (Names & ages) _____

Occupation/s _____

Hours/day _____

Do you drink alcohol? How many drinks per day/week/month? _____

Do you drink caffeinated beverages? How many per day? _____

Do you smoke? Yes or No? How many cigarettes per day/week? Quit
date? _____

Have you tried to quit in the past? What helped or hurt this
process? _____

Have you traveled outside of the U.S. recently? _____

Diet:

Please describe your daily diet:): _____



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Do you drink soda? (amount, type, frequency) _____

What percentage of your meals are fresh cooked foods vs. pre-packaged? _____

Do you go on "diets" often? _____

How many servings of fruit and/or vegetables do you eat per day/week? _____

How many servings of fish do you eat per day/week/month? _____

Do you have "sensitivities" to certain foods? _____

Do you prefer foods that are salty or sweet? _____

Caffeine:

How many caffeinated beverages/foods do you drink per day/week? _____

What kinds of caffeinated drinks do you consume? _____

What time in the day do you typically drink/eat caffeinated products? _____

Exercise/Physical Activity:

Please describe type, duration and frequency:

Do you belong to a gym? How often do you go? _____

Do you have access to a swimming pool? _____

What exercise would you like to try? _____

Any old injuries? _____

Sleep:

How many hours do you typically sleep per night? _____

Do you have difficulty falling asleep? _____

Do you wake up in the middle of the night? How many times? _____

Do you feel "rested" in the morning? _____

Do you take something to fall asleep? Pills? Tea? _____



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Do you snore? If yes, do you snore on your side/back/both positions? _____

Do you use a CPAP machine? When did you start? _____

Does your partner snore? Do you sleep in the same room? _____

Do you sleep with children/pets/ a computer in your bedroom? _____

Does stress typically effect your sleep? _____

Stress:

How often do you feel "stressed"? _____

Do you feel that you have control over your stress? _____

Do you take any medications for stress/anxiety? _____

Do you take any herbals/sleep supplements? _____

Is there a family history of anxiety? Depression? Suicide? _____

Have you ever seen a therapist? When? How often? Last time seen? _____

Have you ever tried massage/guided imagery/biofeedback/acupuncture/breathing exercises? _____

Do you tend to eat more when you are "stressed", or less? _____



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Environment:

Do you work with any harsh or toxic chemicals? _____

Do your hobbies involve any chemicals? (painting, gardening etc.) _____

How old is the house that you live in? _____

Do you live near a busy road or highway? How long? _____

Which cosmetics do you wear? Personal care products? _____

Which cleaning products do you use? _____

Do you work with any harsh/toxic cleaning products? Industrial chemicals? _____

Spirituality:

Please specify your spiritual beliefs/religious affiliation (optional): _____

Who or what gives you emotional support? _____

When have you been most happy? What makes you happy now? _____



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What has been your greatest disappointment/regret in life? _____

What has been your greatest challenge? _____

What has been your greatest source of pride/joy? _____

Anything else you would like to share? _____
