

INTEGRATIVE MEDICINE EVALUATION

Name _____ Age _____ Date of Birth _____ Today's Date _____

A. **CURRENT HEALTH PROBLEMS:** Why are you coming to see Dr. Sullivan-Durand? Please list the physical and emotional symptoms that you would like to address.

1. _____
2. _____
3. _____
4. _____
5. _____

B. **MEDICATIONS/HERBS/SUPPLEMENTS:** Please refer to the bottles of all that you are taking and complete the chart below.
If you need more space, continue on reverse side of this paper.

Prescription Medications		Herbs or Vitamin Supplements		Over the Counter Medications	
Name/ Strength (#mg)	# of pills/# of times per day	Name/ Strength (#mg)	# of pills/# of times per day	Name/ Strength (#mg)	# of pills/# of times per day
e.g. Levothyroxine 25 mcg	2 / 1	Vital Nutrients B complex	1 / 2	Ibuprofen 200 mg	2 / 2-3
_____	_____/_____	_____	_____/_____	_____	_____/_____
_____	_____/_____	_____	_____/_____	_____	_____/_____
_____	_____/_____	_____	_____/_____	_____	_____/_____
_____	_____/_____	_____	_____/_____	_____	_____/_____
_____	_____/_____	_____	_____/_____	_____	_____/_____

C. **ACTIVE HEALTH PROBLEMS** for which you are taking medication or currently receiving other treatment, even if they are stable and will not be addressed by Dr. Sullivan-Durand.

- | | |
|------------------------------|------------------------------|
| 1. _____ Year of Onset _____ | 4. _____ Year of Onset _____ |
| 2. _____ Year of Onset _____ | 5. _____ Year of Onset _____ |
| 3. _____ Year of Onset _____ | 6. _____ Year of Onset _____ |

C. **PAST MEDICAL PROBLEMS** including Significant Childhood Illnesses, Bacterial/Viral infections, Hospitalizations, Surgeries.

Mo/Yr	Illness/Infections/Hospitalizations	Mo/Yr	Surgeries
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

D. ALLERGIES to	MEDICATIONS	FOOD	ENVIRONMENT
List	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

E. Name/Address of Primary Care Provider: _____
Date of Last Office Visit _____ Is your physician aware of your visit with Dr. Sullivan-Durand? _____

F. FIBROMYALGIA/CHRONIC FATIGUE QUESTIONS: Read these questions and complete as they apply. If not, write N/A.

Are you significantly fatigued to the point where it interferes with your life? Yes No

How does the fatigue interfere with your life? _____

What was the approximate date of onset? _____ Did symptoms begin: Suddenly Gradually

Please describe life and health circumstances at the time of onset, including stresses that were present: _____

How many hours per week were you working outside of the home (including commute) at onset? _____

How many hours per week were you working inside the home at onset? _____

How many doctors have you seen for your condition? _____

DIAGNOSTIC CRITERIA FOR CFS: Please complete the following questions.

1. Do you have unexplained, persistent fatigue that is not the result of ongoing exertion, isn't substantially relieved by rest, is of new onset (not lifelong), and results in significant reduction in previous levels of activity? _____ YES _____ NO
2. Have you had any of the following symptoms for six months or more? Check all that apply.
 - a. _____ Impaired memory or concentration
 - b. _____ Post-exertional Malaise (extreme, prolonged exhaustion or sickness after physical or mental activity)
 - c. _____ Unrefreshing Sleep
 - d. _____ Muscle Pain
 - e. _____ Multiple joint pain without swelling or redness
 - f. _____ Headaches of a new type, pattern or severity?
 - g. _____ Sore throat that's frequent or recurrent
 - h. _____ Tender neck or armpit lymph nodes

DIAGNOSTIC CRITERIA FOR FIBROMYALGIA Please complete the following questions.

1. Have you had widespread pain for more than 3 months in all four quadrants of your body (i.e. above and below the waist and on both sides of the body)? _____ YES _____ NO
2. Have you had pain along your spine in your neck, mid-back, or low back or along your anterior chest for more than 3 months at a time? _____ YES _____ NO
3. Have you ever been diagnosed as having Fibromyalgia? _____ YES _____ NO When/By Whom? _____

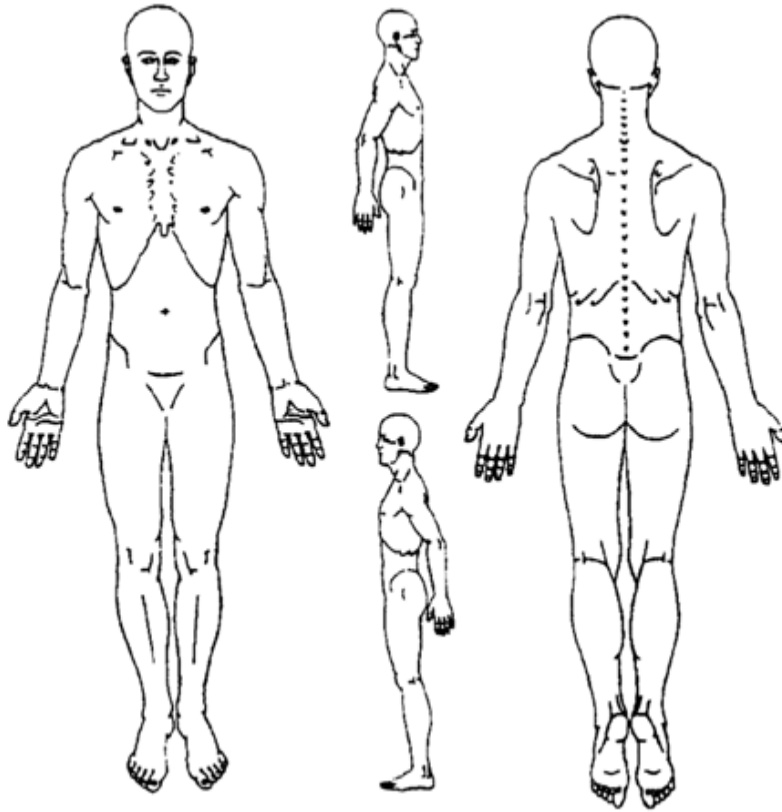
4. Please rate the following symptoms on a scale of 0 (not present), 1-2 (mild) up to 10 (severe)

a. Muscle Pain	0	1	2	3	4	5	6	7	8	9	10
b. Joint Pain	0	1	2	3	4	5	6	7	8	9	10
c. Joint Swelling	0	1	2	3	4	5	6	7	8	9	10
d. Numbness/Tingling	0	1	2	3	4	5	6	7	8	9	10
e. Sleep Problems	0	1	2	3	4	5	6	7	8	9	10
f. Impaired Memory	0	1	2	3	4	5	6	7	8	9	10
g. Impaired concentration	0	1	2	3	4	5	6	7	8	9	10
h. Depression	0	1	2	3	4	5	6	7	8	9	10
i. Anxiety/Nervousness	0	1	2	3	4	5	6	7	8	9	10
j. Headaches	0	1	2	3	4	5	6	7	8	9	10
k. Irritable Bowel	0	1	2	3	4	5	6	7	8	9	10

FOCAL MUSCULOSKELETAL PAIN HISTORY Please complete the following questions:

1. Are there specific areas of pain in your arms, legs, hands, feet, head, neck or back? ____ YES ____ NO

If YES, mark the areas on your body where you feel the described sensations using the symbols given below.



ACHE	
SHARP	
NUMB	
TINGLING	
BURNING	

PAIN HISTORY

What was/were the approximate date(s) of onset? _____ Did symptoms begin: Suddenly Gradually

Was onset due to an injury? ____ YES ____ NO Were you at work or driving a car when you were injured? ____ YES ____ NO

Please list and describe life and health circumstances at the time of onset. _____

Does the pain significantly interfere with your life? ____ YES ____ NO If so, how? _____

TRAUMA/ACCIDENT HISTORY Please complete the following questions for significant accidents/injuries

<u>MO/YR</u>	<u>NATURE OF ACCIDENT</u>	<u>INJURED AREAS</u>	<u>TREATMENT</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G. WOMEN ONLY:

1. Are you still menstruating? Yes / No (If no, go to Question 2.)
 Are your Periods: Regular / Irregular Date of Last Menstrual Period: _____
 Please describe difficulties with menstruation, if any, including PMS : _____

2. If not menstruating, was your menopause: Natural Surgical Chemotherapy-related
 Month/Year of Last Period ____/____. When did your periods become irregular? _____
 Please describe symptoms of menopause, if any: _____

H. SUBSTANCE USE

1. Do you smoke cigarettes? ____yes ____no
 - If yes, how many cigarettes per day? ____ For how many years? ____
 - If no, did you ever smoke? ____yes ____no How many cigarettes a day? ____
 - For how long? ____ Date of last cigarette? _____
2. If you drink alcohol at least once a month, please estimate how much: ____ wine (glasses/week)
 ____beer (glasses/week) ____alcohol (oz/week)
 - Have you ever felt you should cut down on your drinking? ____yes ____no
 - Have people annoyed you by criticizing your drinking? ____yes ____no
 - Have you ever felt bad or guilty about your drinking? ____yes ____no
 - Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (eye opener)
 ____yes ____no
 - Is there a personal or family history of alcoholism? ____yes ____no Who? _____
3. Do you now or have you ever used recreational drugs? ____yes ____no Describe _____

I. ACTIVITY / EXERCISE

1. Do you exercise on a regular basis? ____yes ____no

Activity (e.g., walking, biking, swimming)	Frequency (daily, weekly, monthly)
_____	_____
_____	_____
_____	_____
2. Do you stretch your muscles before of after your workout? Yes / No Before / After
3. Do you perform any weight training? Yes / No What do you do and how often? _____
4. Describe any physical problems that may limit your activity: _____

5. Do you have any questions about exercise? _____

J. SLEEP/REST

1. Number of hours of sleep per night? _____ Do you feel rested upon awakening? Yes / No
2. Problems with insomnia? (Check all that apply)
_____ Trouble falling asleep
_____ Waking in the *middle of the night* and having trouble going back to sleep?
_____ Waking up *too early* and having trouble going back to sleep?
3. Do you nap? Yes / No Duration? _____ Do you feel refreshed? Yes / No
4. Do you use sleeping aids? Yes / No If Yes, for how many months/ years? _____
If yes, please specify type and frequency: _____
5. Have you ever had a Sleep Study? _____ If so, when and where? _____
What were the results? _____

K. RELAXATION

1. Do you meditate or practice a relaxation technique? Yes / No How often? _____
If yes, please check those that apply:
____yoga ____imagery ____abdominal breathing ____meditation ____Tai Chi
____progressive muscle relaxation ____prayer ____other: _____
2. Does it help relieve your feelings of distress? _____

L. METABOLIC

1. What is your current weight: _____lbs Height: _____ft _____in
2. Do you consider yourself (circle one): overweight underweight about right
3. Has your weight changed recently? Yes / No If so, how? _____ lb gain / loss within _____ weeks / months
4. In your adult life: what is the most you ever weighed? _____ lbs What is the least you ever weighed? _____ lbs
5. Have you ever experienced any of the following?
____Fear of getting fat
____Exercise to keep yourself from getting fat
____Avoid fattening foods
____Deny yourself healthy foods to avoid gaining weight
____5 lbs or more weight loss /gain
____Feel depressed, guilty or disgusted with yourself after eating
____Take laxatives, enemas, diuretics or diet pills
____Eat large amounts of food without being able to stop yourself
____Hide evidence of food you have eaten from others
____Eat until uncomfortably full
____Eat large amounts of food when not hungry
____Eat alone because of embarrassment at how much you are eating
____Repeatedly chew, spit out but not swallow large amounts of food
____Make yourself vomit after eating

M. NUTRITION

1. Which meals do you usually eat each day? **A** = Always/Almost Always, **S** = Sometimes, **N** = Never/Almost Never

___Breakfast ___AM snack ___Lunch ___ Afternoon snack ___Dinner ___Evening Snack

2. Are you on a restricted diet? If so, please describe. _____

3. Describe your typical meals. This is a Judgment-Free zone. Please list what you actually eat, not what you think you should eat!

a. Breakfast _____

b. AM Snack _____

c. Lunch _____

d. Afternoon Snack _____

e. Dinner _____

f. Evening Snack _____

4. Do you eat at least five fruits and vegetables each day? ___YES ___NO

5. How many servings of calcium containing products per day (on average)?

6. Are there any factors that make it difficult for you to eat a healthy diet? What are they? _____

7. Do you need more information on healthful eating? ___YES ___NO

8. Have you ever been seen by a dietician for nutrition counseling? YES / NO
Helpful? YES / NO

9. Beverages

a. How many ounces of water do you drink per day? _____

b. How many 8-ounce glasses of milk do you drink per day? _____

c. How many cups of caffeinated beverages per day? Coffee_____ Tea_____ Cola_____ Cocoa_____

d. How many cups of decaffeinated beverages per day? Coffee_____ Tea_____ Cola_____ Cocoa_____

e. How many cups of other beverages per day? Carbonated Soda _____ 100% juices_____ Flavored Juice-drinks _____
Green Tea _____ Other _____ (list _____)

1 "Serving" of Calcium-containing Food has about 250-300 mg of calcium

- 8 oz milk, yogurt, pudding, custard, cottage cheese, or fortified orange juice
- 1 ½ oz hard cheese
- 10 figs
- 1 cup collards
- 2 -3 cups beans
- 1 cup rhubarb
- 4 oz almonds
- 1 cup tofu

P. FAMILY HISTORY

	Age	If deceased, Note Age/Cause	Medical and psychological illnesses
Biological mother	____	_____	_____
Step/Adoptive mother	____	_____	_____
Biological Father	____	_____	_____
Step/Adoptive father	____	_____	_____
Brothers	____	_____	_____
	____	_____	_____
	____	_____	_____
Sisters	____	_____	_____
	____	_____	_____
	____	_____	_____

If your parents are deceased, please indicate your age at the time of their death(s): _____

6. Please describe your childhood, with attention to your relationships with your parents/guardians, siblings as well as any significant trauma or abuse.

7. Please describe your current relationships with members of your family of origin.

Q. ROLES/RELATIONSHIPS

1. Marital status (please check one):

single married living in a committed relationship
 separated divorced widowed (if so, how long?): _____

(If single go to question 3)

2. How many times have you been married? _____

Dates of first marriage: From _____ to _____ Your age at time of first marriage: _____

Describe your first marriage: _____

Dates of second marriage: From _____ to _____ Your age at time of second marriage: _____

Describe your second marriage: _____

Dates of third marriage: From _____ to _____ Your age at time of third marriage: _____

Describe your third marriage: _____

3. How satisfied are you with your sex life? very satisfied satisfied dissatisfied

4. Number of biological/adopted children? _____ Ages/Gender _____

Number of stepchildren? _____ Ages/Gender _____

How many children living at home? _____

6. How many people live in your household? _____

7. Do you have pets? Please list. _____

8. Your occupation: _____ Hours worked/week: _____

How satisfied are you with your job/career? very satisfied satisfied dissatisfied

9. Your spouse/partner's occupation: _____ Hours worked/week _____

10. Education level completed (please circle the highest appropriate number):

Grade School High School College Graduate School

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

11. What resources do you have for emotional support? (check all that apply)

spouse family friends religion/spiritual

other (specify): _____