Crossroads Integrative Medicine
11 Municipal Drive, STE 220
Fishers, Indiana, US - 46038

CIM New Patient Intake Form

Crossroads Integrative Medicine Intake Form

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled appointment time. These questions will help to identify underlying causes of illness and will also assist us in formulating a treatment plan. All information entered into this form is confidential. Please fill it out completely at least 48 hour before your appointment. This allows us to spend more time during your appointment focusing on treatment.

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Gender ☐ Male ☐ Female ☐ Transgender

Preferred Pronoun: ☐ He ☐ She ☐ They

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Primary Contact Details

Caregiver First Name _____

Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

Emergency Contact Number _____

Extn _____

May we contact you at this number to discuss private medical information? * ☐ Yes ☐ No

How did you hear about our clinic? *

What brings you in?

Health Concerns: Please list your most important physical, mental, or emotional health concerns. Indicate which is/are of the most immediate concern to you.

Condition #1 *

Condition #2:

Condition #3:

Condition #4:

Condition #5:

Health Goals: Please list your health goals, ranking the most important first.

#1 *

#2

#3

#4

#5

What are your expectations for your first visit?

How do you rate your overall health? *

☐ Excellent ☐ Very Good ☐ Good
☐ Fair ☐ Poor

Tell us about your past medical issues:

Do you have any known drug allergies? If so, please list the drug and your reaction to that drug *

Any known food allergies? If so, please list the food and your reaction to that food

Please list your current medications and supplements, including dose. This includes all prescribed drugs, vitamins, herbs, and others you are currently taking. (Example – Nordic Naturals Proomega Fish Oil – 3 caps per day) *

Health Care History

Past Surgeries: *

Past Hospitalizations: *

When did you last receive medical care? *

Where (Clinic)? *

By whom (Provider)?

Immunization History

Please indicate if you have received any of the following vaccines.

Hep A	☐ Yes ☐ No
Hep B	☐ Yes ☐ No
HPV	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No
Smallpox	☐ Yes ☐ No
Tetanus (DtAP/TdAP)	☐ Yes ☐ No
Polio	☐ Yes ☐ No
Flu (Seasonal)	☐ Yes ☐ No
Shingles	☐ Yes ☐ No

MMR (Measles/Mumps/Rubella)	☐ Yes ☐ No
Pneumococcal	☐ Yes ☐ No
HiB	☐ Yes ☐ No
Meningococcal	☐ Yes ☐ No
TB	☐ Yes ☐ No
SARS-CoV-2	☐ Yes ☐ No
Others:	

Medical History- Family & Personal

Read this section carefully as several are mandatory to complete the section. Please indicate in detail if you or any of your family members have the following conditions:

ADD/ADHD	☐ Self	☐ Mother	☐ Father
	☐ Grandmother	☐ Grandfather	☐ Aunt
	☐ Uncle	☐ Sister	☐ Brother
	☐ Child		
Alcoholism/Addiction	☐ Self	☐ Mother	☐ Father
	☐ Grandmother	☐ Grandfather	☐ Aunt
	☐ Uncle	☐ Sister	☐ Brother
	☐ Child		
Alzheimers/Dementia	☐ Self	☐ Mother	☐ Father
	☐ Grandmother	☐ Grandfather	☐ Aunt
	☐ Uncle	☐ Sister	☐ Brother
	☐ Child		
Anxiety	☐ Self	☐ Mother	☐ Father
	☐ Grandmother	☐ Grandfather	☐ Aunt
	☐ Uncle	☐ Sister	☐ Brother
	☐ Child		
Arthritis	☐ Self	☐ Mother	☐ Father
	☐ Grandmother	☐ Grandfather	☐ Aunt
	☐ Uncle	☐ Sister	☐ Brother
	☐ Child		

Asthma

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Autoimmune Disease

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

If yes, please specify what type or state unknown.

Cancer

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

If yes, please specify the type, at what age it occurred and if it was the cause of death.

Breast Cancer (Required) *

- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Colon Cancer (Required) *

- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Colitis/Crohn's Disease

- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Diabetes (Required) *

- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

If yes, please specify what type of Diabetes (I, II, LADA).

Depression
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Heart Attack (Required) *
- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Hepatitis
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

High Blood Pressure (Required) *
- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

High Cholesterol (Required) *
- [ ] Not Applicable
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child
- [ ] NA

Kidney Disease
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Osteoporosis
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Seasonal Allergies
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child

Thyroid Disease
- [ ] Self
- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Aunt
- [ ] Uncle
- [ ] Sister
- [ ] Brother
- [ ] Child
- [ ] NA

If yes, was it HYPOthyroid (Low) or HYPERthyroid (High)?

Stroke (Required) *

☐ Not Applicable ☐ Self ☐ Mother
☐ Father ☐ Grandmother ☐ Grandfather
☐ Aunt ☐ Uncle ☐ Sister
☐ Brother ☐ Child

Tell us about your lifestyle:

Social History

Occupation:

Are you:

☐ Married ☐ Separated ☐ Divorced
☐ Single ☐ Widowed ☐ Partner

Have you or do you serve in the military? If so, in what branch and when and where were you deployed.

Do you have a religious or spiritual practice?

Have you traveled outside the US? Where and when?

Have you ever smoked? If so, how many cigarettes per day, for how many years? *

Do you use marijuana? If so, how many times per week? *

Are you currently sexually active? ☐ Yes ☐ No

Have you been in the past? ☐ Yes ☐ No

What type of contraception have you used?

Tell us about what you are currently experiencing:

Please Indicate if you ARE experiencing or HAVE experienced the following symptoms in the last 6 months. Each system needs to be answered. If you do not have any of the symptoms listed, select "None of the Above"

General *
- [ ] Fevers
- [ ] Night Sweats
- [ ] Heat intolerance
- [ ] Cold Intolerance
- [ ] Cold hands and feet
- [ ] Headaches
- [ ] Migraines
- [ ] Trouble falling asleep
- [ ] Trouble staying asleep
- [ ] Dizziness/Vertigo
- [ ] None of the above

Head *
- [ ] Hair loss
- [ ] Flaking scalp
- [ ] None of the above

Eyes *
- [ ] Itching eyes
- [ ] Blurring
- [ ] Pain
- [ ] Disturbance in vision
- [ ] Contacts/glasses
- [ ] Cataracts
- [ ] Sensitivity to bright light
- [ ] Damage to eyes
- [ ] None of the above

Ears *
- [ ] Ringing in ears
- [ ] Pain in ears
- [ ] History of ear infections as a child
- [ ] History of ear infections as an adult
- [ ] Ear tubes placed
- [ ] Difficulty hearing
- [ ] None of the above

Nose *
- [ ] Congestion
- [ ] Sneezing
- [ ] Pain
- [ ] Difficulty breathing through nose
- [ ] Post nasal drip
- [ ] Frequent Colds
- [ ] None of the above

Mouth *
- [ ] Sores in mouth
- [ ] Cavities
- [ ] Mercury fillings
- [ ] History of root canals
- [ ] Antibiotic use following dental procedure
- [ ] None of the above

Throat *
- [ ] Difficulty swallowing
- [ ] White spots in mouth
- [ ] Sores in mouth
- [ ] None of the above

Lungs *
- [ ] Shortness of breath
- [ ] Difficulty breathing
- [ ] Well controlled Asthma
- [ ] Symptomatic Asthma
- [ ] Cough
- [ ] Congestion
- [ ] Pain with breathing
- [ ] History of pneumonia
- [ ] History of bronchitis
- [ ] None of the above

Cardiovascular system *
- [ ] Racing heart beat
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Murmurs
- [ ] Irregular Heart Beat
- [ ] Chest pain
- [ ] Arm pain
- [ ] Jaw pain
- [ ] Swelling of ankles
- [ ] None of the above

Digestion *
- [ ] Nausea
- [ ] Vomiting
- [ ] Stomach Pain
- [ ] Heartburn
- [ ] Gas
- [ ] Bloating
- [ ] Constipation
- [ ] Diarrhea
- [ ] Blood in stool
- [ ] Hemorrhoids
- [ ] None of the above

Urinary *

- [ ] Difficulty Urinating
- [ ] Pain with Urination
- [ ] Urinary Frequency
- [ ] Urgency to Urinate
- [ ] Incontinence
- [ ] Urinary Tract Infections
- [ ] Kidney Infections
- [ ] Kidney Stones
- [ ] None of the above

Women's Reproductive *

- [ ] Not Applicable
- [ ] Irregular Periods
- [ ] Monthly cycles that last longer than 30 days
- [ ] Monthly cycles shorter than 21 days
- [ ] Pain before period
- [ ] Clotting during period
- [ ] Abnormally heavy periods
- [ ] Periods lasting longer than 7 days
- [ ] Breast tenderness before/during periods
- [ ] Nipple discharge
- [ ] Breast Lumps
- [ ] Mood swings
- [ ] Sweet cravings
- [ ] Salt cravings
- [ ] Currently on birth control pill
- [ ] History of taking birth control pill
- [ ] Problems with infertility
- [ ] Itching
- [ ] Redness
- [ ] Sense of Pelvic Fullness
- [ ] Vaginal Dryness
- [ ] Poor Libido
- [ ] Pain with Sex
- [ ] History of Hysterectomy
- [ ] None of the Above

If you have experienced menopause, when did it begin?

Date of Last PAP:

Have you ever had an abnormal PAP?

Male Reproductive *

- [ ] Not applicable
- [ ] STDs
- [ ] Split urine stream
- [ ] Abnormal discharge
- [ ] Loss of libido
- [ ] Inability to have or maintain erections
- [ ] Painful erections or ejaculation
- [ ] Prostate tenderness
- [ ] History of elevated PSA on a blood test
- [ ] Lump in testicle
- [ ] Painful testicle
- [ ] None of the above

Have you had a prostate exam? If so, when?

Skin *

- [ ] Rashes
- [ ] Itching
- [ ] Unusual moles
- [ ] Lumps
- [ ] Eczema
- [ ] Psoriasis
- [ ] Hives
- [ ] Rosacea
- [ ] Acne
- [ ] None of the above

Nails *

- [ ] White spots on nails
- [ ] Vertical ridges in nails
- [ ] None of the above

Musculoskeletal *

- [ ] Neck pain
- [ ] Upper Back Pain
- [ ] Lower back pain
- [ ] Shoulder pain
- [ ] Elbow pain
- [ ] Wrist Pain
- [ ] Hip pain
- [ ] Knee Pain
- [ ] Ankle Pain
- [ ] Muscle Pain
- [ ] None of the above

What are the top 5 sources of stress in your life?

What behaviors or lifestyle habits do you engage in that you believe support your health?

What behaviors or lifestyle habits do you engage in regularly that you believe are harmful to your health?

What potential challenges do you foresee that could make it difficult to make healthy changes?

Who do you know that will sincerely and consistently support you as you make healthy changes?

What brings you joy in your life?

Tell us about what you tend to eat:

What do you typically eat for the following times of day?

When you wake up:

Mid-morning:

Mid-Day

Mid-Afternoon

Evening:

How many glasses of...

Water/day

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Coffee/day _____

Alcohol/week _____

Juice/day _____

Soda/day _____

Do you have the support of family and friends to make positive changes in your life?

☐ Yes ☐ No

Have you been exposed to any of the following on a regular basis at home or at work?

☐ Gas heat ☐ Oil heat ☐ Electric heat
☐ Wood stove ☐ Air Conditioning ☐ Electric Blanked

What type of water do you most regularly drink?

☐ Distilled ☐ Filtered ☐ Spring
☐ Well ☐ Tap/City

Aknowledgment -- *

☐ I certify that the information I have provided on this questionnaire is truthful and complete to the best of my knowledge. I will not hold Crossroads Integrative medicine accountable for any omission I may have made in the completion of this form.

PATIENT SIGNATURE _____