

Name:

MR #:

Tao Institute of Mind and Body Medicine

PATIENT MEDICAL INTAKE QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your responding thoughtfully and accurately to both these written questions and those posed by the doctor 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 consultation time. The answers to these questions will help us identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ - _____ Birth Date: ____/____/____ Age: _____

Work Phone: (_____) _____ - _____ Ht. ____' ____" Wt. _____

Cell Phone: (_____) _____ - _____ Email: _____

May we have your permission to send information about Center activities by email? Yes _____ No _____

How did you hear about the Center? _____

Emergency Contact (name and phone #): _____

Pharmacy Phone: _____ Today's Date: _____

Do you have an advanced directive (circle one)? Yes No, I need information

For JMBCIM Staff use

Appointment requested with (Tao Institute Provider/s): Bettina Herbert, MD

Fee: \$275 Initial Visit ; \$195 for Follow-Up _____

Appointment scheduled for (date and time): _____

Past medical records and tests received (list): _____

Name:

MR #:

Describe your primary health and wellness goals:

1. _____

2. _____

3. _____

Note: Please provide all reports, letters, lab work, etc. that can help to evaluate and treat the problems listed below.

Describe your most important problem (include diagnosis date if appropriate):

What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your second most important problem (include diagnosis date if appropriate):

What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

Describe your third most important problem (include diagnosis date if appropriate):

What treatments have been recommended for this so far?	
Success obtained with those treatments:	
Future treatments recommended (if any):	

What medications (***not supplements***) are you taking now? Include non-prescription / OTC drugs.

Name:

MR #:

Medication Name/Strength	AM/Noon/PM	Date Started	Medication Name / Strength	AM/Noon/PM	Date Started

Do you have any allergies (circle one)? **Yes** **No**
If yes, list and describe:

List all vitamins, minerals, and other nutritional supplements you are taking now. Indicate whether mg or IU (i.e. the quantity) and the form (i.e., calcium carbonate vs. calcium lactate). If you need more space please list in a separate sheet. You may bring a photocopy of the supplement container labels.

Vitamin/Mineral/ Supplement Name/Strength	AM/Noon/PM	Date Started	Vitamin/Mineral/ Supplement Name/Strength	AM/Noon/PM	Date Started

Name:

MR #:

Other Medical and Surgical History (check and indicate date of diagnosis for each):

√	ILLNESS	DATE	√	ILLNESS	DATE
	Anemia			Hepatitis	
	Arthritis			High blood fats (cholesterol, triglycerides)	
	Asthma			High blood pressure (hypertension)	
	Bronchitis			Irritable bowel syndrome	
	Cancers			Kidney stones	
	Chronic Fatigue Syndrome			Mononucleosis	
	Crohn's Disease or Ulcerative Colitis			Osteopenia / Osteoporosis	
	Depression, Anxiety or Bipolar Disorder: Describe			Pneumonia	
	Diabetes			Rheumatic fever	
	Emphysema			Rheumatoid Arthritis	
	Epilepsy, convulsions, seizures			Sinusitis	
	GERD/ Ulcers			Sleep apnea	
	Gallstones			Stroke and/ or TIAs	
	Gout			Thyroid disease	
	Heart problems: Describe			Other: Describe	
Comments:					

INJURY (back, head, neck, broken bone, sprain, tear, concussion, or other)	DATE	DESCRIPTION (e.g., fall, accident, or other physical trauma)

OPERATIONS/HOSPITALIZATIONS (Include dental procedures)	DATE	COMMENTS/DESCRIPTION

Name:

MR #:

DIAGNOSTIC STUDIES: List studies completed within the past two years. Provide copies if available.

DIAGNOSTIC STUDY	DATE	RESULTS	DIAGNOSTIC STUDY	DATE	RESULTS
Latest blood work			CAT Scan of (list all)		
Bone Scans (describe)			NMR/MRI of (list all)		
X-rays: describe			Upper GI Series		
Thermography			Lower GI: Describe		
Heart Tests: (describe)			Colonoscopy		
Pet Scan			DXA scan (bone density)		
Other (describe)			Other (describe)		
Comments:					

Vaccines:

Please list the dates of the most recent vaccines you have received (if you are unsure, list either the approximate date or write 'unsure'):

Vaccine	Date
Tetanus	
HHV	
Flu	
Pneumonia	
Shingles	
Other (describe)	

Family Medical History:

Illness	Family members who have or have had illness	Illness	Family members who have or have had illness
Arthritis		Diabetes	
Alcohol or Drug Abuse		Heart disease	
Cancer: Breast		High blood pressure	
Cancer: Colon		Other:	

Name:

MR #:

Illness	Family members who have or have had illness	Illness	Family members who have or have had illness
Cancer: Prostate		Other:	
Cancer: Other		Other:	
Depression or Bipolar Disorder		Other:	

Substance Use:

Cigarettes Never Used Smoked from age _____ to _____, _____ packs per day.

Other Tobacco Never Used Cigars Pipes Snuff Chewing Tobacco
Used from age _____ to _____, _____ times per day.

Alcohol Never Used Estimate drinks per week: _____ Alcohol problem from age _____ to _____

Use of other recreational drugs? Yes No If yes, specify:

Wellness Practices:

What exercise do you do? How often? For how long?

What mind-body practice do you have (e.g. meditation, yoga, prayer)? How often?

What wellness therapies do you receive on a routine basis? Acupuncture Chiropractic
 Energy work Massage Other:

What are your leisure activities / hobbies?

Challenges and Stressors / Emotional and Psychological Well-Being:

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

How do you believe those sources of stress affect your daily life?

What major life decisions or changes are you facing?

Describe major losses experienced in the past 3 years:

Have you had emotional trauma (circle one)? **Yes** **No**
If yes, please describe:

Name:

MR #:

Review of Systems* Do you have any of the following symptoms or problems (check any that apply)?

General	
Fatigue	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>
Eyes	
Blurry vision	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>
Ears / Nose / Throat / Sinuses	
Hearing loss	<input type="checkbox"/>
ringing in ears	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>
Pain	<input type="checkbox"/>
Frequent canker sores	<input type="checkbox"/>
Heart / Circulation	
Palpitations or irregular pulse	<input type="checkbox"/>
Chest discomfort (tightness/pressure/pain)	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>
Lungs	
Shortness of breath	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Digestion / Elimination	
Heartburn	<input type="checkbox"/>
Nausea / Vomiting	<input type="checkbox"/>
Abdominal pain / cramps	<input type="checkbox"/>
Abdominal bloating	<input type="checkbox"/>
Bladder / Kidneys / Urination	
Frequent infections	<input type="checkbox"/>
Urgency	<input type="checkbox"/>
Difficulty urinating	<input type="checkbox"/>

Pain with urination	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>
Urinary leakage	<input type="checkbox"/>
Muscles / Bones / Joints	
Muscle pain	<input type="checkbox"/>
Muscle cramps or spasms	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>
Joint pain / stiffness / swelling	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>
Nervous system	
Headaches	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>
Balance problems	<input type="checkbox"/>
Weakness / numbness / tingling sensations	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>
Concentration problems	<input type="checkbox"/>
Allergies / Immune System	
Seasonal or other allergies	<input type="checkbox"/>
Hormonal / Endocrine	
Excessive thirst	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>
Cold or heat intolerance	<input type="checkbox"/>
Blood	
Easy bruising	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>
Skin	
Rashes	<input type="checkbox"/>
Eczema	<input type="checkbox"/>

*Adapted with the permission of the Institute for Functional Medicine

Rate your overall level of energy between 0 and 100%? _____ Average # of hours of sleep? _____
Rate in general how rested you felt within the first hour upon awakening after an adequate amount of sleep during the past month (Use scale: 0 (not rested at all) - 10 (very rested) _____

BM frequency (circle one): > 3x / day 1-3x / day 4-6x / week 1-3x / week or fewer

Describe any noteworthy characteristics regarding BM consistency or color (e.g. loose, small/hard, green, etc): _____

Intestinal gas (circle all that apply): Daily Occasionally Excessive Present with pain Foul smell

Name:

MR #:

For Women Only:

of pregnancies: _____ Are you pregnant now (circle one)? **Yes** **No**
Are you breastfeeding now (circle one)? **Yes** **No**

of term births _____ # of abortions _____ # of preemies _____ # of miscarriages _____

Birth weight of largest baby _____ Smallest baby _____

Toxemia - high blood pressure (circle one)? **Yes** **No**

Other problems with pregnancy _____ Age at first period _____

Date of Last Pap Smear _____ Results (circle one): **Normal** **Abnormal**
Date of Last Mammogram _____ Results (circle one): **Normal** **Abnormal**

Date of last period _____ Date of hysterectomy, if applicable: _____

Do you still have your ovaries (circle one)? **Yes** **No** Are you sexually active (circle one)? **Yes** **No**
If yes, do you use protection? _____

Can you achieve orgasm (circle one)? **Yes** **No**

Have you ever used birth control pills (circle one)? **Yes** **No**

If yes, currently, (circle one)? **Yes** **No** Does/did taking the pill agree with you (circle one)? **Yes** **No**

Do you currently use contraception (circle one)? **Yes** **No**
Type? _____

Are you in menopause (circle one)? **Yes** **No** If yes, age at last period _____

Do you experience (circle all that apply):

Hot flashes	Night Sweats	Vaginal Dryness	Emotional Upheavals
Insomnia	Anxiety	Low Sex Drive	Mental Fog
Tiredness	Difficulty keeping lean weight on	Difficulty with workout results	

Do you take (circle all that apply):
Estrogen **Ogen** **Estrace** **Premarin** **Progesterone** **Provera**
Other: _____

Did you take HRT at one time (circle one)? **Yes** **No**
If yes, how long have you been or were you on HRT _____

In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS) (circle one): **Yes** **No** **Not applicable**

Name:

MR #:

For Men Only (check all that apply):

Discharge from penis		Impotence	
Ejaculation problem		Lumps in testicles	
Genital pain		Poor libido (sex drive)	

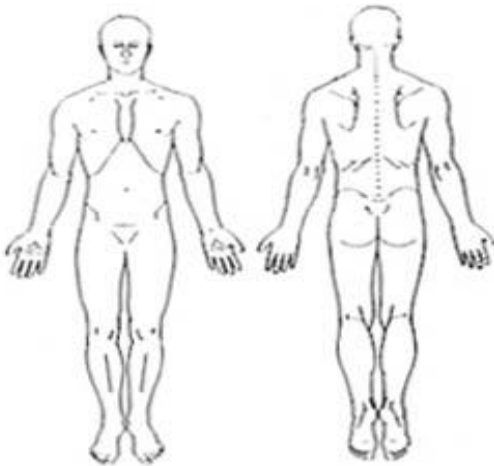
PAIN ASSESSMENT:

If one of your primary problems is pain, please fill out the following:

Do you have a problem with pain that adversely affects your ability to live your life (circle one)?

Yes No

Using the diagram, please circle the location(s) where you have experienced pain in the last month.



When did the pain start?

Has the pain worsened (circle one)?

Yes No

If yes, when did the pain worsen?

CONSTANT or INTERMITTENT (circle one)

Please circle a number to indicate the worst level of pain you have experienced in the past month:

No pain Worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle a number to indicate the average level of pain that you have experienced in the last month:

No Pain Worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

What have you tried to lessen the pain (circle all those that apply):

Acupuncture

Osteopathy

Surgery

Chiropractic

Movement Re-education (e.g. Feldenkrais)

Massage

Physical therapy

Other: _____

Name:

MR #:

Dietary Information: Place a check mark next to the food / drink that applies to your current diet. (check all that apply).

Usual Breakfast		Usual Lunch		Usual Dinner	
None/Miss		None/Miss		None/Miss	
Main Choices		Leftovers		Leftovers	
Eggs		Main Choices- Sandwiches		Main Choices – Protein	
Oatmeal / Hot cereal		BLT		Beans	
Cold cereal		Chicken/Turkey		Fish	
Any yogurt		Fish		Poultry	
Cheese		Lettuce/tomato/mayo		Meat	
Other Choices		Meat		Any cheese	
Bacon		Vegetable/cheese		Yogurt	
Bagel		Main Choices – Salads		Main Choices – Complex Carbohydrates	
Coffee		Chef’s salad		Rice	
Donut		Caesar salad		Potatoes	
Fruit		Mixed vegetable		Pasta	
Beverages		Salad dressing		Carrots	
Coffee		Any Yogurt or Cheese		Winter squash	
Tea		Beverages		Low Carb Vegetables	
Juice		Coffee		Greens	
Water		Soda		Yellow Vegetables	
Milk		Tea		Green beans	
Other: (List below)		Water		Beverages	
		Milk		Coffee	
		Dessert		Soda	
		Cookies		Tea	
		Fruit		Water	
		Other: (List below)		Milk	
				Dessert	
				Cookies	
				Fruit	
				Other: (List below)	

How much of the following do you consume each week?

Item	Amount	Item	Amount
Candy / Ice Cream		Slices of white bread (rolls/bagels)	
Cheese / Yogurt		Regular / diet sodas with / without caffeine	
Chocolate		Cups of decaffeinated tea / coffee	
Cups of coffee with caffeine		Cups of tea with caffeine	

Name:

MR #:

Environmental Exposures (check all that apply):

√	Item	√	Item
	Regular exposure to second-hand smoke		Do you feel worse during: <input type="checkbox"/> spring <input type="checkbox"/> fall <input type="checkbox"/> summer <input type="checkbox"/> winter
	Mercury (silver) amalgam fillings		Exposure to toxic metals at home or work? <input type="checkbox"/> lead <input type="checkbox"/> cadmium <input type="checkbox"/> aluminum <input type="checkbox"/> arsenic <input type="checkbox"/> mercury
	Root canals? # _____		Reaction to flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe _____
	# of cavities in last 2 years _____		Reaction to pneumonia (Pneumovax) shot ? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe _____
	Bleeding gums		Travel outside US: When/Where
	Artificial joints or implants		

Antibiotics / Oral Steroids (check all that apply):

How often have you taken Antibiotics?	Less than 5 times	5 times or more	How often have you taken oral steroids(Cortisone, Prednisone)	Less than 5 times	5 times or More
Infancy/Childhood					
Teen Years					
Adulthood					

Genetic Testing:

Are you interested in any of these preventive tests for personalized genetic analysis of (please circle all that apply):

1. Cardiovascular System Health
2. Bone Health
3. Immune System Health
4. Detoxification Systems Make Up
5. Inflammatory Predisposition Make Up

When complete, mail this form to:

Tao Institute of Mind and Body Medicine
14 South Bryn Mawr Avenue, Suite 101
Bryn Mawr PR 19010

Or FAX or email to:

610-520-1331 or
HandsOnMedicine@gmail.com