PATIENT/CLIENT INTAKE FORM

Please allow 30-45 minutes to complete most of this questionnaire. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you and for the purpose of using the most respectful language when addressing you. That said; please answer only the questions you are comfortable answering.

PATIENT/CLIENT CONTACT

Patient/Client Name: _____ (Last Name / First Name / Middle Name) DOB _____

What is your preferred pronoun? (Add drop down options)

What is your preferred name? (Nickname, chosen name, etc.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Preferred Contact Number: ☐ Cell ☐ Home ☐ Work

HOW DID YOU HEAR ABOUT US?

Walk-in Friend Family Work Student Referring Physician

Healthcare Provider Newspaper Mailer Sign/Billboard Television Social Media MUIH Website

Magazine/Published Material Wellness Minute on Facebook Other _____

PRIMARY CARE PROVIDER

Name: _____ Phone Number _____

Address _____ Fax Number _____

☐ I do not have Primary Care Provider.

EMERGENCY CONTACT

Name:_____ Relationship:_____

Phone Number:_____

DEMOGRAPHICS

What is your gender? ☐Male ☐Female Other_____

Interpreter needed? ☐Yes ☐No Primary Language: _____

Ethnic Group (Select One): ☐Hispanic ☐Non-Hispanic Are you a US Veteran? ☐Yes ☐No

Race (Select all that apply): ☐Asian ☐African American ☐Caucasian ☐Alaskan Native ☐Pacific Islander ☐American Indian

Relationship Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered ☐Separated

Highest Level of Education: _____

Occupation: _____

Employer: _____

Employment Status (Check one): ☐Full Time ☐Not Employed ☐Part Time ☐Retired ☐Seasonal ☐Self Employed ☐Volunteer

☐Student (Full Time) ☐Student (Part Time) ☐MUIH Student

I certify the above information is true and correct to the best of my knowledge.

_____

Printed Name of Legal Guardian (if under 18 years of age)

_____ _____

Signature of Client or Legal Guardian Signature **Date**

REASONS FOR SEEKING CARE –

1. What is your main reason for coming to the clinic today?

2. Are you seeking care for specific health problems, symptom, or conditions? (Please list)

MEDICAL HISTORY: PERSONAL & FAMILY

Current Height:

Current Weight:

What, if any, surgeries, operations, or procedures have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations?
If so, when and for what reason(s)?

Personal & Family Health History:
Please check box to indicate if you or a biological family member has ever had the following conditions. If condition does not apply, leave blank.
For personal health history, indicate P for past conditions or C for current conditions.

Medical Condition	Self	Mother	Father	Sibling(s)	Other family member
Allergies					
Alcohol/Drug Addiction					
Anemia					
Anxiety					
Arthritis					
Cancer					
Cataracts					
Clotting disorder					
Depression					
Diabetes					
Fibromyalgia					
GERD					
Glaucoma					
Heart Disease					
High Cholesterol					
High Blood Pressure					
HIV/AIDS					
Irritable Bowel Syndrome					
Kidney Disease					
Lyme Disease					
Mental Illness (other than anxiety or depression)					
Nerve/Muscle Disease					
Osteoporosis					
Parkinson's/dementia/Alzheimer's					
PTSD					
Respiratory Diseases (e.g., COPD, emphysema)					
Seizures					
Sickle cell anemia					
Stroke					
Thyroid disease					
Ulcers					
Vision problems					
Other					

For Women:

Pregnancies *(please include losses/terminations)*			
Year	Vaginal/C Section	Sex	Complications/Other Things You Want to Mention

Are you currently pregnant? Are you actively trying to conceive? Are you breastfeeding?

Date of last menstrual period:

How long is your cycle?

How long between cycles:

Do you have any issues with mood changes, pain/cramping, or other menstrual concerns?

Do you utilize contraception? Yes / No

If yes, what type(s)?:

HEALTH-RELATED BEHAVIORS

DIET

1. In general, how healthy is your overall diet?
   Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent ☐

2. Are you satisfied with your diet? Yes/No

SLEEP	
At what time are you typically in bed?	
What time do you fall asleep?	
Do you have difficulty falling asleep?	
Do you have difficulty staying asleep?	
Typical total hours asleep?	
# of times you awaken during the night	
Do you feel rested upon rising?	

PHYSICAL ACTIVITY	
How would you categorize your activity level?	Sedentary ☐ Mildly Active ☐ Moderately Active ☐ Very Active ☐
How many days per week do you exercise?	
What types of exercise do you do? (Check all that apply)	Cardio ☐ Strength ☐ Flexibility ☐ Endurance ☐ Balance ☐
What is the general intensity when you exercise?	Mild ☐ Moderate ☐ Strenuous ☐

STRESS							
On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:							
Work:		Social/family situation:		Current health status:		Life in general:	
What do you do to cope with stress?							
Do you feel that your current state of health is:	largely in your control or largely out of your control						

LIFESTYLE

1. What are your hobbies and interests?

2. How do you typically spend your day?

3. With whom do you live? (Include roommates, spouse, children, relatives, pets, etc.)

	Frequency					Comments
	Never	less than once/month	Monthly	Weekly	Daily	
Social Activity						
Relaxation						What types(s)?
Spiritual/Religious practice						
Mindfulness Practices						What type(s)?
Alcohol						
Tobacco						
Recreational Drugs						
Sexual Activity						

Significant Life Events:

Please list any major events of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, and anything else you feel greatly impacted your life.

Date Event

MEDICATIONS/SUPPLEMENTS

Please list any medications you are taking currently or take on a regular basis (including over the counter medications)

Name	Dose	Frequency	Reason for Taking	Prescribing Provider	Start date

Please list any herb, vitamin, or supplement products you are taking currently or take on a regular basis. Please include brand names. If your product has a number of ingredients it can be helpful to bring it with you to your visit.

Name	Dose	Frequency	Reason for Taking	Start date

HEALTH ASSESSMENT/SYMPTOM QUESTIONNAIRE

Medical Symptom Questionnaire

Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

Point Scale:
O = Never or almost never have the symptom.
1 = Occasionally have it; effect is not severe.
2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

Digestive Tract
_____ Nausea or vomiting
_____Diarrhea
_____Constipation
_____Bloated feeling
_____Belching or passing gas
_____Heartburn
_____**Total**

Ears
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____**Total**

Emotions
_____Mood swings
_____Anxiety, fear, or nervousness
_____Anger, irritability or aggressiveness
_____**Total**

Energy/Activity
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____**Total**

Eyes
_____Watery or itchy eyes
_____Swollen, reddened, or sticky eyelids
_____Bags or dark circles under eyes
_____Blurred or tunnel vision
_____Slurred speech
_____**Total**

Mouth/Throat
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums, lips
_____Canker sores
_____**Total**

Head
_____Headaches
_____Faintness
_____Dizziness
_____Insomnia
_____**Total**

Heart
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest Pain
_____**Total**

Joints/Muscles
_____Pain or aches in joints
_____Arthritis
_____Stiffness or limitation in movement
_____Pain or aches in muscles
_____Feeling of weakness or tiredness
_____**Total**

Lungs
_____Chest congestion
_____Asthma, bronchitis
_____Shortness of breath
_____**Total**

Mind
_____Poor memory
_____Confusion, poor comprehension
_____Poor concentration
_____Difficulty in making decisions
_____Stuttering or stammering
_____Learning disabilities
_____**Total**

Skin
_____Acne
_____Hives, rashes, or dry skin
_____Hair Loss
_____Flushing or hot flashes
_____Excessive sweating
_____**Total**

Nose
_____Stuffy nose
_____Sinus problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____**Total**

Weight
_____Binge eating/drinking
_____Craving certain foods
_____Excessive weight
_____Compulsive eating
_____Underweight
_____Water retention

Other
_____Frequent illness
_____Genital itch or discharge
_____**Total**

_____**Grand Total**

Is there anything else that you would like your provider to know?

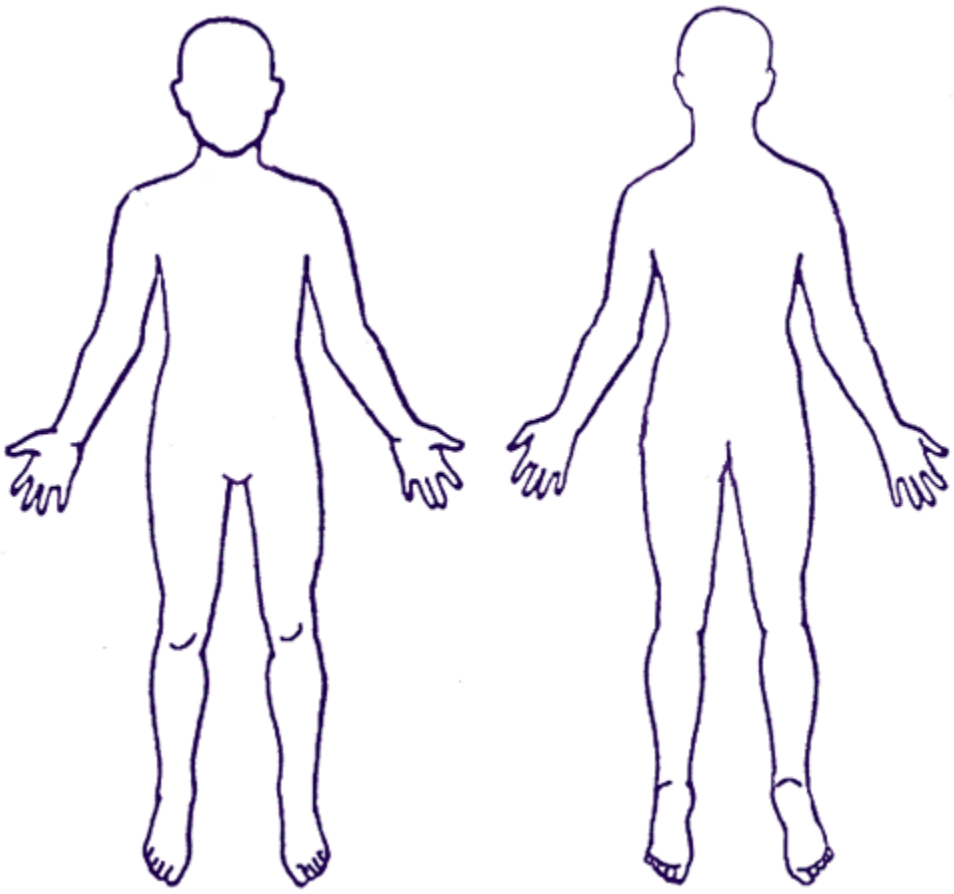
Thank you for taking the time to complete this questionnaire.

YOGA THERAPY INTAKE FORM CONTINUED

Please Circle any areas of pain/concern. You will be able to discuss this with your Yoga Therapist.

(Describe pain, does anything make it better/worse?)

Front Back



Do you eat regular meals? Y N

How much water do you drink daily?

How much caffeine do you consume in a day?

Please circle any of the following sensations you may be experiencing

Negative Self-Talk Fear Grief Anger Sadness Despair Other (please explain)

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Please respond to each question or statement by marking one box per row.

	Physical Function	**Without any difficulty**	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA23	Are you able to go for a walk of at least 15 minutes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	Anxiety **In the past 7 days…**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDANX01	I felt fearful	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX40	I found it hard to focus on anything other than my anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX41	My worries overwhelmed me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDANX53	I felt uneasy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Depression **In the past 7 days...**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
EDDEP04	I felt worthless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP06	I felt helpless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP29	I felt depressed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
EDDEP41	I felt hopeless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	Fatigue **During the past 7 days…**	**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI7	I feel fatigued	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
AN3	I have trouble starting things because I am tired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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Fatigue

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
FATEXP41	How run-down did you feel on average? ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
FATEXP40	How fatigued were you on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Sleep Disturbance

	In the past 7 days…	Very poor	Poor	Fair	Good	Very good
Sleep109	My sleep quality was.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
Sleep116	My sleep was refreshing.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep20	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep44	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Ability to Participate in Social Roles and Activities

		Never	Rarely	Sometimes	Usually	Always
SRPPER11_CaPS	I have trouble doing all of my regular leisure activities with others.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER18_CaPS	I have trouble doing all of the family activities that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER23_CaPS	I have trouble doing all of my usual work (include work at home)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
SRPPER46_CaPS	I have trouble doing all of the activities with friends that I want to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Pain Interference

	In the past 7 days…	Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ9	How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ22	How much did pain interfere with work around the home?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ31	How much did pain interfere with your ability to participate in social activities? .	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ34	How much did pain interfere with your household chores?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PROMIS–29 Profile v2.1

Pain Intensity

In the past 7 days…

Global07	How would you rate your pain on average?.....	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**