



Integrative Family Health Associates

Have you ever had a drink first thing in the morning (eye opener to steady your nerves or to get rid of a hang-over)? _____ Yes _____ No

Have you ever felt bad or guilty about your drinking? _____ Yes _____ No

4. Do you use recreational drugs? _____ Yes _____ No

5. NUTRITION

Do you consider yourself: _____ Overweight? _____ Underweight? _____ Just right?

What is your ideal weight? _____ Has your weight changed recently? _____ Yes _____ No

Have you ever been seen by a dietician for nutrition counseling? _____ Yes _____ No

Do you have any issues with eating? _____

Do any of the factors listed below make it difficult for you to eat right?

_____ eating out _____ taking large portions

_____ frequent snacking _____ moods

_____ someone else cooks _____ I need information on healthful eating

Do you eat at least two fruits and vegetables each day? _____ Yes _____ No

Are you on a special diet? (Please describe) _____

Do you drink caffeinated beverages? _____ Yes _____ No

If yes, please indicate the number of cups per day: _____ coffee _____ tea

_____ cola _____ cocoa

6. ACTIVITY/EXERCISE

How active are you? _____ very _____ moderately _____ sedentary

Do you have any physical problems that limit your activity? _____ Yes _____ No

If yes, please describe: _____

Do you regularly exercise? _____ Yes _____ No

If yes, sessions/week: _____ minutes/session _____



_____ sadness _____ anger _____ depression

10. ROLE/RELATIONSHIPS

How many people live in your household? _____

Social roles (Please check all roles that apply to you):

_____ friend _____ parent _____ employer

_____ spouse _____ caretaker _____ child

_____ employee

Can you count on anyone to provide you with emotional support? _____ Yes _____ No

If yes, check all that apply:

_____ spouse _____ family _____ friend

_____ pet _____ religion/spiritual _____ other

11. SEXUALITY

How satisfied are you with your sex life? _____ very satisfied _____ satisfied

_____ dissatisfied

12. STRESS

Do you feel you have an excessive amount of stress in your life? _____ Yes _____ No

Do you meditate or practice a relaxation technique? _____ Yes _____ No

If yes, sessions per week _____ minutes per session _____

If yes, please check all those that apply:

_____ yoga _____ imagery _____ abdominal breathing

_____ prayer _____ tai chi _____ meditation

_____ progressive muscle relaxation _____ other



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What is your perception of daily stressors that interfere with your life?

(Please circle the number corresponding to each, 0 being no stress and 10 being worst stress possible)

Work	0	1	2	3	4	5	6	7	8	9	10
Family	0	1	2	3	4	5	6	7	8	9	10
Social	0	1	2	3	4	5	6	7	8	9	10
Finances	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Living situation											
	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

What attitudes, assumptions, and beliefs help you cope when life is stressful? _____

13. Have you ever been abused, a victim of a crime, or experienced a trauma? ____ Yes ____ No

14. VALUES/BELIEFS

Are there religious or spiritual practices that are meaningful to you? ____ Yes ____ No

If yes, please describe: _____

15. TREATMENT GOALS

What is your motivation for seeking a consultation? _____

What goals do you hope to achieve? _____

Thank you for your time and for filling this form out as completely as possible. Please remember all information given is strictly confidential.



Informed Consent for Consultative Services

I understand that only the physicians and naturopathic physicians at Integrative Family Health Associates (“IFHA”) are practicing medicine and prescribing any type of pharmaceuticals. I recognized that all non-physician providers are facilitating my health and well-being within the scope of their training and any licenses, and do not diagnose illness.

It has been made clear to me that non-physician services are not a substitute for medical examination, nor are non-psychotherapist services a substitute for a psychological exam. I understand that it is recommended that I see a physician or psychotherapist (either at IFHA or an outside provider) should those service be required or advised.

I take responsibility for keeping IFHA apprised as to my state of health and all known medical conditions. I know that I am encouraged to discuss any question or concerns with my provider(s).

I have read the above, and voluntarily consent to the treatment and education at IFHA.

X _____ Date _____