Cooper University Health Care

COOPER INTEGRATIVE MEDICINE PROGRAM

Patient Information Form

Please take a moment to tell us about yourself. All questions are optional.

Name: ______________________________

Address: ______________________________

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Preferred Phone: ______________________________

Email: ______________________________

Emergency Contact: ______________________________

How did you hear about our program? ______________________________

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What are your expectations for the integrative medicine consultation? ______________________________

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Please circle "E" if you have Experience with, or "I" if you have Interest in any of the following.

Prayer	E	I	Yoga	E	I
Meditation	E	I	Acupuncture	E	I
Mindfulness	E	I	Supplements	E	I
Tai chi	E	I	Essential oils	E	I
Chi gong	E	I	Chiropractor	E	I
Massage	E	I	Reiki	E	I
Homeopathy	E	I	Nutrition	E	I
Biofeedback	E	I	Hypnosis	E	I
Vitamins	E	I	Energy medicine	E	I
Aromatherapy	E	I	Dance	E	I
Ayurveda	E	I	Chinese medicine	E	I
Breathwork	E	I			

Other ______________________________

Please list all of your current healthcare providers:

Primary care physician: ______________________________

Specialists: ______________________________

____

Psychiatric/psychologic: ______________________________

Complementary medicine: ______________________________

____

Other providers/services: ______________________________

____

Please list ALL of your current medications and dosages (include all medications, vitamins, supplements and herbal remedies):

Medication name	Dose	Date started

Please list any allergies you have:

Medication allergies: ______________________________

Food allergies: ______________________________

Other allergies: ______________________________

____

Please briefly list your hospitalizations and surgeries:

____

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____

____

Please list dietary preferences/usual dietary choices:

Breakfast: ___

Lunch: ___

Dinner: ___

Snacks: ___

Other: ___

Cravings: ___

Do you consume any of the following (please circle):

Beer   Wine   Other alcohol   Tobacco   Caffeine   Marijuana   Others

If so, how much per day? ___

What exercises/activities do you enjoy? ___

What exercises/activities do you currently participate in? ___

Please list your greatest stressors in order of greatest to least: ___

Please list your greatest comforts: ___

Please tell us about your sleep habits:

Average time to bed: ___ Average wake up: ___ Average time asleep: ___

Marital Status

Are you married? Yes No   Divorced? Yes No   Widowed? Yes No

Do you belong to an organized religious group? **Yes** **No**

If yes, please describe: ______________________________

What is your current job/profession: ______________________________

Do you have chronic pain: **Yes** **No**

If yes, please describe: ______________________________

____

Please rate the following in terms of quality in your life:

(1 being lowest quality and 10 being the highest)

Physical health	1	2	3	4	5	6	7	8	9	10
Emotional health	1	2	3	4	5	6	7	8	9	10
Physical pain	1	2	3	4	5	6	7	8	9	10
Spouse	1	2	3	4	5	6	7	8	9	10
Children	1	2	3	4	5	6	7	8	9	10
Family	1	2	3	4	5	6	7	8	9	10
Sexual relationship	1	2	3	4	5	6	7	8	9	10
Friendships	1	2	3	4	5	6	7	8	9	10
Job/career	1	2	3	4	5	6	7	8	9	10
Financial health	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Energy level	1	2	3	4	5	6	7	8	9	10
Time management	1	2	3	4	5	6	7	8	9	10
Overall stress	1	2	3	4	5	6	7	8	9	10
Spirituality	1	2	3	4	5	6	7	8	9	10
Love	1	2	3	4	5	6	7	8	9	10

PERSONAL AND FAMILY SYMPTOMS/HISTORY: **Please check any of the following that apply:**

Condition/Symptom	Please list detail:	You	Mom	Dad	Grand Parent	Sibling	Child
Abdominal pain/ indigestion							
Alcoholism or addiction							
Alzheimer's disease/ Memory loss							
Allergies							
Anger/Irritability							
Anemia							
Arthritis/Joint pain							
Anxiety/Nerves							
Panic attacks							
Autoimmune Disease							
Asthma							
Birth defects							
Bleeding							
Breast pain, problems							
Cancer							
Colitis/							
Crohn's disease							
CHF							
COPD							
Constipation, chronic							
Cough, chronic							
Depression/Suicidal thoughts							
Diabetes							
Diarrhea, chronic							
Drug use							
Eczema							
Endocrine problems							
Fainting, syncope							
Fatigue/ Chronic Fatigue							
Frequent infections							
Glaucoma/Cataract							
Gout							
Hearing loss/Tinnitus							
Herpes							
Heart disease							

PERSONAL AND FAMILY SYMPTOMS/HISTORY: Please check any of the following that apply:

Condition/Symptom	Please list detail:	You	Mom	Dad	Grand Parent	Sibling	Child
Heart attack							
High blood pressure							
High cholesterol							
HIV/AIDS							
Hives/Urticaria							
Impotence/Erection problems							
Infertility							
Insomnia/Sleep issues							
Kidney							
disease							
Liver disease/Hepatitis							
Lyme disease							
Menstrual problems/PMS							
Mental illness							
Migraine							
Nausea/Vomiting							
Neuropathy							
Obesity							
Osteoporosis							
Peptic ulcer							
Prostate problems							
Psoriasis							
Other rashes							
Sexually transmitted infection							
Seizures, epilepsy							
Sinus problems							
Stroke							
Thyroid disease							
Urinary problems							
Vaginal problems							
Vertigo							
Vitamin deficiencies							
Weight gain, unexplained							
Weight loss, unexplained							
Other							
Other							
Other							

Have you ever experienced any physical, emotional or sexual abuse? If so, please describe:

Please rate the happiness of your childhood on a scale from 1-10:

(1 being extremely unhappy to 10 joyful and ideal for you)

1 2 3 4 5 6 7 8 9 10

What are your biggest fears?

If there is one thing you can change/have in your life, what would it be?

Is there anything else you'd like us to know prior to your visit?

Thank you for sharing this information. We ask that send your completed form at least **TWO DAYS** prior to your scheduled visit.

Please return the form via mail, fax, or email.

Mail to:
Integrative Medicine Program
The Ripa Center for Women's Health and Wellness
6100 Main Street Promenade
901 Centennial Boulevard
Voorhees, NJ 08043

Fax to:
856.673.4497

Scan and email to:
IntegrativeMed@CooperHealth.edu

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