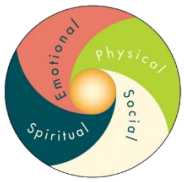
Dear Valued Patient,

Thank you for choosing the UNM Center for Life (CFL) for your healthcare needs. We're committed to providing you excellent care!

About Us:

- Center for Life uses a variety of ancient and modern treatment methods. Our practitioners make use of all appropriate conventional and complementary therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing.
- Doctors throughout the UNM health system refer to us for:
  - **Common problems like:**
    - Anxiety & Muscle Tension
    - Stomach Discomfort
    - Headaches and Migraines
  - **Serious or Chronic diseases like:**
    - Chronic Pain
    - Hypertension
    - Diabetes
    - Cancer Support
- **Why patient's choose Center for Life:**
  - Patients consistently rank us in the top 10% on the leading national patient satisfaction survey, Press-Ganey.
  - Our medical doctors (MD), acupuncturists, chiropractor, and massage therapists all use UNM's electronic health record to coordinate your care with doctors throughout UNM.
  - Center for Life providers care about the time you wait for them. Because we care, we're ready for you when you arrive and rarely run more than a few minutes behind schedule. To get the most out of your Center for Life visit, please have your health form completed before your visit.
  - Exceptional care in a healing environment.

Your time is valuable. Thank you for taking the time to share this important health information with us!



How did you hear about us? (Select all that apply.)	Community Wellness Programs		Health Care Provider	Personal Referral
	☐ Health Fair	☐ Email	☐ Primary Care	☐ Family
	☐ Presentation	☐ Employer	☐ Other	☐ Friend
	☐ UNM	☐ Other _____	_____	☐ Coworker
				Name: _____

Name:	DOB:	Gender:	Male	Female

Address:	City:	State:	Zip Code:

If the Doctor needs to reach you, what is the best phone number?	1st Choice:	2nd Choice:

Updated 10/10/2019

Are you a veteran? Yes No			
Would you like to receive information about Center for Life classes & events?	No	Yes	**Email Address:**

Who has recommended our practice to you? Name(s): _____

Provider History:

A key focus of Integrative Medicine is working closely with your other healthcare providers.
Please list the names of each of your other providers & either their phone # or location.

1. Primary Care Provider: (The provider you see for routine healthcare needs.)
   _____
2. Specialty Care Provider: (The provider treating specific health conditions, e.g. cardiologist.)
   _____
3. Referring Provider: (The provider who referred you to your appointment today.)
   _____
4. Other (mental health, massage, acupuncturist, etc.):
   _____

What are the top 3 things you want to get out of your visit to Center for Life?

_____
_____
_____
_____
_____

Medical History:

Female Health History:

- Age of first menses: _____ Date/Duration of last menstrual period: _____ Age of Menopause: _____
- Pregnancies: _____ Abortions: _____ Miscarriages: ____ Live Births: _____ Premature Births: _____
- Please share with us any other female health history that may be pertinent._____
  _____

Medication / Supplement History:

Please list any: 1. **Prescription** (Rx) 2. **Over-the-Counter** (OTC) medications you are taking. 3. **Supplements**	Medication / Supplement	Dose (how many)	Frequency (how often)
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
	7.		
	8.		
	9.		

Please list any **Allergies** or sensitivities you have to 1) Medication; 2) Food; and/or 3) the Environment (e.g. pollen, animals, molds, etc.).	What are you allergic to?	What happens when you're exposed to this allergen? (e.g. itching, sneezing, etc.)
	1.	a.
	2.	b.
	3.	c.

General Health:

• How would you rate your general health?	Poor	Fair	Ok	Good	Great
• How would you rate your health as a child?	Poor	Fair	Ok	Good	Great
• How would you rate your energy level during the past month?	Poor	Fair	Ok	Good	Great
• How would you rate your sleep during the past month?	Poor	Fair	Ok	Good	Great
• What is your stress level during the past month?	Low	Medium		High	

• In order of importance, what causes the most stress in your life? (Job, Relationships, Health, Finances, etc.)	1.	2.	3.
• What brings you happiness?			

Diet and Nutritional History:

• How would you rate your current eating habits?	Poor	Fair	Ok	Good	Great	
• In the past 24 hours, what have you eaten for:						
1. Breakfast:						
2. Lunch:						
3. Dinner:						
4. Snacks:						
• Is this what you eat on a typical day?	Yes			No		
1. If not, why not?						
• How many times do you eat out per week?	0	1-2	3-5	6-10	10+	
• When you cook, what types of oils do you use?						
• Do you get cravings for certain foods? What do you crave?						
• Are there any types of foods you avoid? What do you avoid?						
• What do you drink on a typical day? (Coffee, soda, juice, water, etc.)						
1. How many 8 oz cups of water do you drink on a typical day?						
2. Which types of caffeine do you drink?	Coffee	Energy	Soda		Tea	
3. How much of each do you drink?						
• How many servings of fruit do you eat on a typical day? (Serving = 1 cup raw or ½ cup cooked)	0	1	2	3	4	
• How many servings of vegetables do you eat on a typical day? (Serving = 1 cup raw or ½ cup cooked)	0	1	2	3	4	
• Current Weight:	• Highest Ever Weight:		• Desired Weight:			

Review of Systems:

General: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Recurrent infections
2. Night Sweats
3. Sweating easily
4. Weight gain / loss
5. Sudden Energy drops
6. Fever/Chills
7. Fatigue
8. Poor balance
9. Bleed or bruise easily
10. Strong thirst (hot/cold)
11. Thirst / lack of thirst
12. Other _____

Skin: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Rashes
2. Itching
3. Oozing
4. Pimples/Acne
5. Dry skin/scalp
6. Change in hair
7. Change in skin
8. Other: _____

Head/Eyes/Ears/Nose/Throat: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Headaches
2. Dizziness
3. Earache
4. Poor Hearing
5. Ringing in Ears
6. Blurry Vision
7. Night Blindness
8. Spots in front of Eyes
9. Eye Pain
10. Excessive Tearing
11. Glasses
12. Dry Eyes/Mouth
13. Facial Pain
14. Nose Bleeds
15. Nasal Discharge
16. Blocked Nose
17. Snoring
18. Grinding Teeth
19. Teeth Problems
20. Hoarseness
21. Recurrent Sore Throat
22. Swollen Glands
23. Sore on Lips/Mouth
24. Other: _____

Cardiovascular: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Pacemaker
2. High Blood Pressure
3. Low Blood Pressure
4. Heart Palpitations
5. Chest Discomfort/Pain
6. Swelling of Legs
7. Blood Clots
8. Varicose Veins
9. Fainting
10. Cold Hands or Feet
11. Other: _____

Respiratory: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Difficulty Breathing
2. Pain with Breathing
3. Shallow Breathing
4. Shortness of Breath
5. Production of Phlegm
6. Recurrent Cough
7. Coughing Blood
8. Bronchitis
9. Pneumonia
10. Asthma/Wheezing
11. Use C-Pap
12. Other: _____

Digestion: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Change in Appetite
2. Abdominal Pain/Cramps
3. Nausea / Vomiting
4. Reflux
5. Heartburn. Belching
6. Belching
7. Pain with Passing Stools
8. Constipation
9. Loose Stools/Diarrhea
10. Hemorrhoids
11. Rectal Pain
12. Gas
13. Other ____

Genito-Urinary: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Pain upon Urination
2. Frequent Urination
3. Blood in Urine
4. Night Incontinence
5. Impotency
6. Kidney Stones
7. Prostate Problems
8. Urgency with Urination
9. Decrease in Urinary Flow
10. Inability to Empty Bladder
11. Increase/Decrease in Sex Drive
12.Wake to Urinate
13. Unable to Hold Urine
14. Numbness in Anal or Genital Area
15. Other: _____

Gynecological: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. PMS
2. Irregular Periods
3. Painful Periods
4. Light Periods
5. Heavy Periods
6. Clots
7. Infertility
8. Unusual Vaginal Discharge
9. Vaginal Sores
10. Bleeding after Sex
11. Breast Lumps
12. Nipple Discharge
13. Other: _____

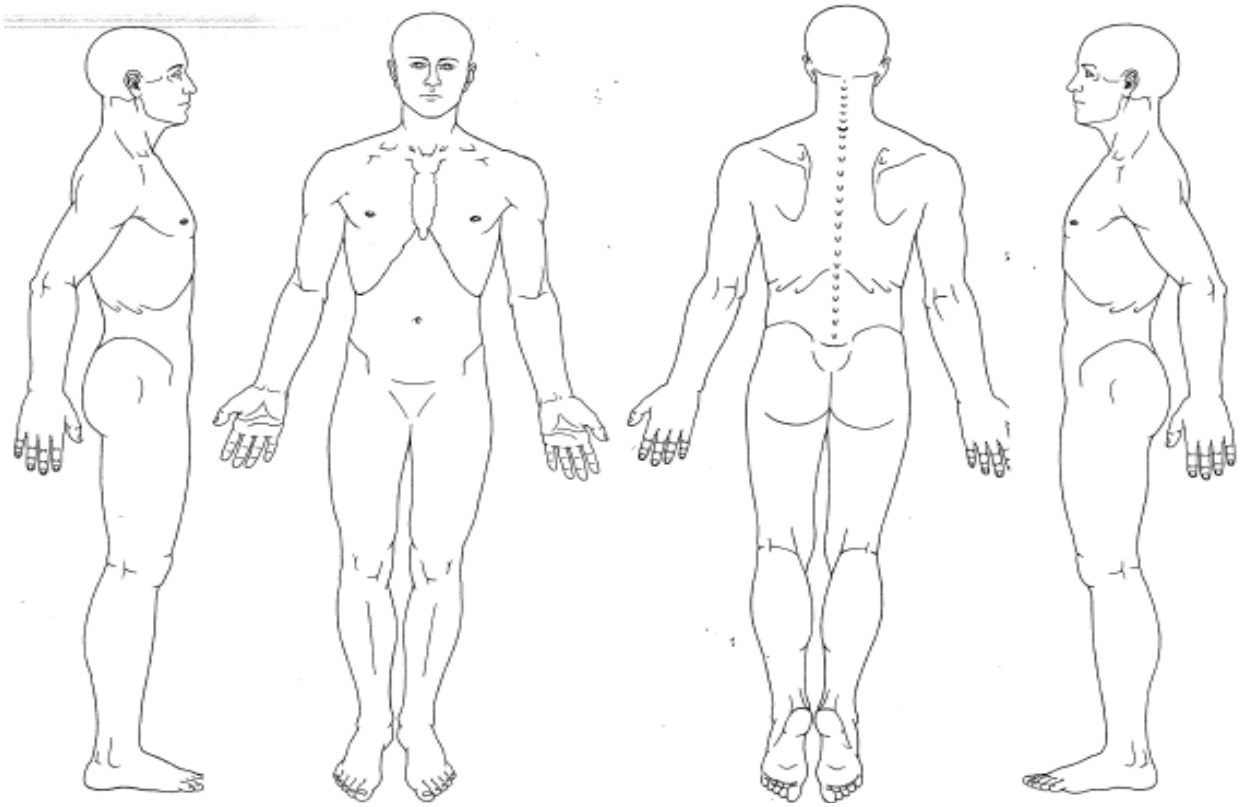
Neurological: (Please circle any symptoms you have experienced **in the last 6 months**).

1. Seizures
2. Paralysis
3. Dizziness
4. Poor Memory
5. Difficulty Concentrating
6. Weakness/Numbness
7. Lack of Coordination
8. Tremors
9. Other _____

Emotional: (Please circle any symptoms you have experienced **in the last 6 months**.)

1. Vacant
2. Moody
3. Bad Temper
4. Lose Control of Emotions
6. Depression
7. Fear
8. Anxiety or Panic
12. Eating Disorder
13. Other: _____

Pain: (Please mark the areas where you are in pain.)



Area #	Current Pain Rating (0-low to 10-high)	Quality of the Pain (Stabbing, burning, throbbing, numb, aching, pins/needles)	When did the Pain Start?	Did the pain start around the time of an injury?		Have you had any of these tests to evaluate the pain? Xray, MRI, CT, labs		Has the pain caused you to lose time from work, change your daily activities, or lose sleep?	
1.				Yes	No	Yes	No	Yes	No
2.				Yes	No	Yes	No	Yes	No
3.				Yes	No	Yes	No	Yes	No
4.				Yes	No	Yes	No	Yes	No

Do you have chronic pain? ☐ **Yes** ☐ **No** (skip section) ***Chronic pain is pain lasting more than **3 months**.***

Rating Scale: *0 = No Pain; 10 = Worst Pain You've Ever Had*

1. How severe is your chronic pain RIGHT NOW?	0	1	2	3	4	5	6	7	8	9	10
2. How severe is your chronic pain ON AVERAGE?	0	1	2	3	4	5	6	7	8	9	10
3. What is your LOWEST level of chronic pain in the past week?	0	1	2	3	4	5	6	7	8	9	10
4. What is your HIGHEST level of chronic pain in the past week?	0	1	2	3	4	5	6	7	8	9	10

What treatments and/or medications do you take for pain?

Treatments:	1.	2.	3.
Medications:	1.	2.	3.
Over-the-Counter Meds:	1.	2.	3.

How much RELIEF have pain treatments or medications provided in the last week?

Rating Scale: *0 = No Relief 10 = Complete Relief*

1. Treatment #1:	0	1	2	3	4	5	6	7	8	9	10
2. Treatment #2:	0	1	2	3	4	5	6	7	8	9	10
3. Treatment #3:	0	1	2	3	4	5	6	7	8	9	10
4. Medication #1:	0	1	2	3	4	5	6	7	8	9	10
5. Medication #2:	0	1	2	3	4	5	6	7	8	9	10

6. Medication #3:	0	1	2	3	4	5	6	7	8	9	10
7. Over-the Counter Medication #1:	0	1	2	3	4	5	6	7	8	9	10
8. Over-the Counter Medication #2:	0	1	2	3	4	5	6	7	8	9	10
9. Over-the Counter Medication #3:	0	1	2	3	4	5	6	7	8	9	10

During the past Week how has pain interfered with your Quality of Life?

Rating Scale: *0 = Does Not Interfere* *10 Completely Interferes*

1. General Activities of Living	0	1	2	3	4	5	6	7	8	9	10
2. Mood	0	1	2	3	4	5	6	7	8	9	10
3. Walking Ability	0	1	2	3	4	5	6	7	8	9	10
4. Normal Work (outside home & house work)	0	1	2	3	4	5	6	7	8	9	10
5. Relationships with Other People	0	1	2	3	4	5	6	7	8	9	10
6. Sleep	0	1	2	3	4	5	6	7	8	9	10
7. Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

Is there anything else you would like to share with us about yourself, your life or your health?

_____

_____

Family Health History	Father	Mother	Brother	Sister	Mother's Father	Mother's Mother	Father's Father	Father's Mother	Any of Your Kids
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood Disorder (like anemia or leukemia)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder (problems with blood clots or bleeding)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol or Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach or Intestine Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
Immune Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness (like depression or anxiety)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle or Bone Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pancreas Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
TB (Tuberculosis)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐

Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine or Cervical Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐

Social History:

Do you drink alcohol?
☐ Never ☐ Yes, I do now
☐ I have in the past ☐ Other: _____
What kind of alcohol do you drink? Beer
☐ Beer ☐ Wine ☐ Liquor ☐ Other: _____
How often do you drink?
☐ 1-2 times per year ☐ 1-2 times per month
☐ 1-2 times per week ☐ 3-5 times per week
☐ Daily ☐ Several times per day ☐ Other: _____

How many drinks do you normally have at one time? _____
What is the most number of drinks you have had at one time in the last year? _____
Has alcohol caused problems with your work or home?
☐ Yes ☐ No
Do you want to make a change in your alcohol use?
☐ Yes ☐ No

Do you have a job?
☐ Full time ☐ Part time
☐ Retired ☐ Student
☐ Unemployed ☐ Other: _____
What is your job? _____
What is the activity level of your job?
☐ Sitting at a desk in an office
☐ Physical work only once in a while
☐ Medium amount of physical work
☐ A lot of physical work
☐ Other:

Please check your highest level of school.
☐ Less than high school
☐ High school diploma or GED
☐ Some college
☐ College degree
☐ Graduate Degree
☐ Other: _____

How many minutes do you exercise each week? ____
How many times a week do you exercise?
☐ Never ☐ 5-6 times/week
☐ 1-2 times/we ☐ Daily
☐ 3-4 times/week ☐ Other: _____

What would you say your fitness level is?
☐ Poor ☐ Excellent
☐ Fair ☐ Other: _____
☐ Good
What kind of exercise do you do?
☐ Walking ☐ Weight Lifting
☐ Fitness Class ☐ Yoga
☐ Running ☐ Sports
☐ Swimming ☐ Other: _____

Who do you live with?
☐ Alone ☐ Brothers & Sisters
☐ Children ☐ Significant Other or Partner
☐ Father ☐ Spouse
☐ Mother ☐ Other: _____

Where do you live?
☐ Home with No Help ☐ Hospice
☐ Home with Help ☐ Other _____
☐ Nursing Home

Do you have any religious concerns or rules that you need to follow?
☐ Rules about blood products
☐ Rules about what you can eat
☐ Rules about your caregiver being a man or a woman
☐ Other religious concerns: _____

Have you used drugs that you did not get from a doctor?
☐ Never ☐ I have in the past
☐ Yes, I do now ☐ Other: _____
If you do use drugs or have in the past, please mark which ones:
☐ Amphetamines
☐ Cocaine
☐ Ecstasy

Do you use any tobacco?
☐ None
☐ Yes, every day smoker
☐ Yes, sometimes I smoke
☐ Former smoker
☐ I don't want to answer
☐ Unknown
☐ I use other tobacco products ☐ Other: