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Integrative Medicine is an approach which treats the whole body and mind. In an effort to get to know you, please complete this questionnaire as thoroughly as possible and bring this to your appointment. Please answer as much or as little as you like, but the more complete and honest your answers are, the more we will have to discuss. If there are questions that you would rather discuss in-person, please make a note, and we may do so at your appointment. I look forward to meeting you. Be well.

Supak Sookkasikon MD

Patient Intake Form

Name	Date of Birth	Appointment Date/Time
Address	City	State, Zip
Email	Phone ( )	Phone ( )

What are your goals for this visit? _____
_____
_____

Concern (please rank by priority) Onset Frequency Severity
Example: Headaches June 1998 4 times/week mild/mod/severe
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical History Please indicate if you have/or have ever had

	Past	Present		List family members who have had these illnesses (siblings, parent, children, grandparent)
Heart Disease	☐	☐	_____	_____
Hypertension	☐	☐	_____	_____
Cancer	☐	☐	_____	_____
Diabetes	☐	☐	_____	_____
Lung Disease (asthma etc)	☐	☐	_____	_____
Hepatitis	☐	☐	_____	_____
Digestive Disorders	☐	☐	_____	_____
Seizures	☐	☐	_____	_____
Thyroid Disease	☐	☐	_____	_____

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Other _____ ☐ ☐ _____
Other _____ ☐ ☐ _____
Other _____ ☐ ☐ _____
Other _____ ☐ ☐ _____
Comments
_____
_____

Allergic reaction to medications

Medication	Reaction/Intolerances

Operations / Injuries

What	When	What	When

Occupation

_____

What hobbies/interests do you have?

_____
_____

Who do you live with? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you participate in?

_____
_____

What are the major stressors in your life?

_____
_____

What do you do to relax?

_____
_____

Religious affiliation, past and present

_____
_____

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What prior experiences have you had with alternative medicine?

_____
_____

Tobacco ☐ Never Used ☐ Smoked from age _____ to _____. _____ packs per day.

Alcohol ☐ Never Used ☐ Estimated drinks per day _____.

Recreational Drugs ☐ Never Used ☐ Frequency _____.

Comments_____
_____

What medications are you taking now? (include prescription and over-the-counter drugs.)

Medication Reason	When	Started	Dosage per day	Cost

What vitamins/minerals/supplements are you taking now?

Brand or Other name (manufacturer)	Reason	When started	Dosage per day	Cost
Example: St John's Wort (nature's Way)	***Feeling Down***	***June 09***	***3 caps***	***15.00/30***

Continue on last page if necessary

Nutrition Evaluation

Please list ***all*** foods and drinks you have consumed in the previous 24 hours.
Include meals, snacks, beverages and condiments.

Food Item	How prepared (baked, fried etc)	Amount (cup, tbs, ounces etc)

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Is this a typical day? If not, why? Please describe:

_____
_____
_____
_____

How many servings of fruit do you eat/drink per day?
(serving = 1 small piece of fruit, ½ cup juice, ½ cup canned or chopped fruit, ½ cup dried fruit)

_____

How many servings of vegetables do you consume each day?
(serving = ½ cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, ¼ cup dried vegetables, or 1 small piece)

_____

Are you currently on a special diet? If so, please describe:

_____
_____
_____
_____

Do you eat out or cook? Who cooks?

_____

What type of oil or spreads do you add to your food?

_____
_____

What do you drink on a typical day?

_____
_____

How would you describe your relationship with food?

_____
_____
_____

How many hours of sleep do you get a night? Is it interrupted? Why? Do you have social support? If you have a problem, is there someone you can talk to? If not, how do you deal with your problems?

_____

Are you happy with your life? Is there anything you want to change about your life?

_____

What makes you happy?

_____

What makes you sad?