Welcome to Sage Integrative Medicine

Please complete the questions below so we may serve you better.
We respect the confidential nature of this information, and will not release it without your permission, or as required by law. Thank you.

Date: _____

Initial Health Information

Name ~~(Last, First, MI)~~ _____
Date of Birth ___/___/_____ Height:_____ Weight: _____ Age _____ Gender: ▫ M ▫ F
Phone: _____ Cell Phone: _____ Email: _____
Best means of contacting you: ▫ Phone ▫ Cell Phone ▫ Email
How did you hear about Sage Integrative Medicine and/or Dr. Roemmelt?

_____

Do you understand your Patient Rights? ▫ Yes ▫ No

History of Present Illness:

What do you hope to achieve from your visit to Sage Integrative? _____

_____

Are you experiencing a present health problem? (Please list) _____

_____

When did it begin? _____

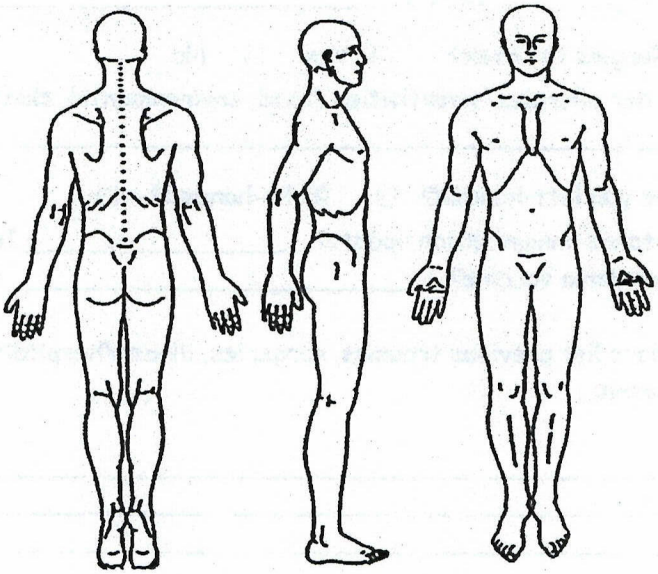
How frequently do you experience symptoms? (Please circle) Infrequently Intermittently Constantly

How long do your symptoms last? _____

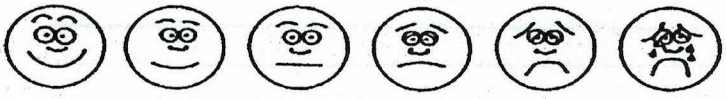
How would you describe the pain? (circle) Burning Numbness Aching Stabbing Other _____

What, if anything, makes it better? _____

What, if anything, makes it worse? _____



Please use this scale to indicate your current level of discomfort / pain, and indicate region.



Patient Name _____ Date of Birth ___/___/_____

Past Medical History

Please check any of the following conditions you have now or have had in the past:

Now	Past		Now	Past		Now	Past	
☐	☐	Anemia	☐	☐	Epilepsy or Seizures	☐	☐	Motion Sickness
☐	☐	Anxiety/Panic Attacks/Fears	☐	☐	Eye/Visual Problems	☐	☐	Multiple Sclerosis
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Muscle, Bone, Joint Injury
☐	☐	Asthma	☐	☐	Fractures, Broken Bones	☐	☐	Neckaches
☐	☐	Backaches	☐	☐	Gynecological/Pregnancy	☐	☐	Nervous System Disorders
☐	☐	Bleeding Disorders/clots	☐	☐	Headaches	☐	☐	Neuritis
☐	☐	Cancer	☐	☐	Heart Disease/Heart Attack	☐	☐	Numbness/Tingling
☐	☐	Chronic Earaches	☐	☐	Heart Murmur	☐	☐	Osteoporosis
☐	☐	Chronic Fatigue	☐	☐	Heart Surgery	☐	☐	Pacemaker/any implants
☐	☐	Circulatory Problems	☐	☐	Hernia	☐	☐	Parkinson's Disease
☐	☐	Concussion/Head Injury	☐	☐	High Blood Pressure	☐	☐	Pneumonia
☐	☐	Constipation	☐	☐	High Cholesterol	☐	☐	Rheumatic Fever
☐	☐	Contact Lenses	☐	☐	Immune System Disease	☐	☐	Sinus Trouble
☐	☐	Depression/Mental Illness	☐	☐	Incontinence	☐	☐	Skin Disorders
☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Sleep Disturbance
☐	☐	Difficulty Swallowing	☐	☐	Liver Disease/Hepatitis	☐	☐	Stroke
☐	☐	Digestion/Intestinal Issues	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Dizziness	☐	☐	Lung Disease	☐	☐	Tinnitus
☐	☐	Ear/Hearing Problems	☐	☐	Memory Problems	☐	☐	Tuberculosis/PPD+
☐	☐	Emphysema/Bronchitis	☐	☐	Metal Implants	☐	☐	Varicose Veins

Please list any medications/vitamins/supplements/herbal products that you are currently taking: _____

_____

_____

_____

_____

Allergic to medications? _____

Allergies to Latex? ☐ Yes ☐ No

Other allergies/sensitivities (food, environmental, skin) _____

_____

Are you left-handed? ☐ Right-handed? ☐

Tetanus immunization update? _____ Influenza or flu vaccine? _____

Pneumonia vaccine? _____ Other recent vaccine? _____

Please list previous traumas, surgeries, illness/hospitalizations:

Reason: Date:

_____

_____

_____

Have you had any prior: (please list reason, date, and outcome)
Physical/Occupational Therapy: _____
Massage Therapy: _____
Acupuncture: _____
Chiropractic: _____
Nutritional Consultation: _____
Counseling: _____

Reproductive History (for women only):

Age menstruation began: _____ Length of usual menstrual cycle: _____
Number of pregnancies: _____ Number of miscarriages: _____
Do you have irregular menstruation: _____ If yes, which type? early / late / spotting / irregular cycle

Are you pregnant now? ☐ Yes ☐ No If yes, how many weeks?_____

Have you reached menopause? ☐ Yes ☐ No If yes, at what age? _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, at what age? _____

Have you had problems with infertility? ☐ Yes ☐ No Have you had toxemia? ☐ Yes ☐ No

Have you had problems with fibroids? ☐ Yes ☐ No Have you had gestational diabetes? ☐ Yes ☐ No

Family History:

Age (if deceased, please list cause of death and age) **Medical and Psychological Illnesses**

Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Partner/Spouse: _____
Children: _____

Social History

Is English your primary language? ☐ Yes ☐ No If no, what is? _____
Highest level of education attained: _____

Do you exercise: ☐ Yes ☐ No If yes, what type and how often? _____
How do you relax? _____
What brings you joy? _____
Do you meditate or practice a relaxation technique? _____
Describe any current emotional or life stressors: _____
_____
Please list your hobbies: _____

Are there any religious, cultural or spiritual needs pertinent to your treatment? ☐ Yes ☐ No
If yes, please describe: _____
How do you learn best? Seeing Hearing Doing Reading

Are you interested in learning more about your health condition? ☐ Yes ☐ No
Do you use an assistive device, including wheelchair, splint or cane? _____

Do you need assistance with transportation? ☐ Yes ☐ No

Do you need assistance with daily activities? ☐ Yes ☐ No
If yes, please describe: _____

Do you live alone? ☐ Yes ☐ No If no, with whom do you live? _____

Have you smoked, or do you smoke tobacco of any kind? ☐ Yes ☐ No

How much? _____ How long? _____ Have you quit? ☐ Yes ☐ No

If not, would you like assistance in quitting? ☐ Yes ☐ No

Do you chew tobacco? ☐ Yes ☐ No
How many drinks of alcohol do you average daily? _____ Weekly? _____

Do you use recreational drugs, i.e. marijuana, cocaine, stimulants? ☐ Yes ☐ No

In the last year have you ever drunk alcohol or used drugs more than you meant to? ☐ Yes ☐ No

In the last year, have you ever felt you wanted, or needed, to cut down on drinking or drug use? ☐ Yes ☐ No

Do you consider yourself: Overweight Underweight About right
Please note any significant changes in your weight: _____

Do you consider yourself to have healthy eating habits? ☐ Yes ☐ No

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

Do you have at least three servings of calcium-containing food each day? ☐ Yes ☐ No

How many caffeine products do you consume daily, i.e. coffee, tea, cocoa, cola? _____

If you follow a special diet, please list the type: _____

Would you like information or assistance with nutrition-related health concerns/conditions? ☐ Yes ☐ No
Check if you presently have:

☐ Unusual fatigue ☐ Sleep Disturbance ☐ Frequent sad or depressed thoughts

☐ Reduced concentration ☐ Social withdrawal

Are you now, or have you been, subject to physical abuse, threats, harm or neglect? ☐ Yes ☐ No
If yes, please explain _____
_____
_____

Occupational History:

Are you working now? ☐ Yes ☐ No If yes, list your occupation _____

How long at this job? _____ How long with this employer? _____ Describe your work duties _____

Does your job involve prolonged: Sitting Heavy Lifting Exposure to toxic chemicals Repetitive motions

Please describe _____

_____

How much do you work? Hours per day: _____Hours per week: _____

Is your health problem related to work? ☐ Yes ☐ No ☐ Unknown

If yes, please explain: _____

Do you have a second job? ☐ Yes ☐ No If yes, please describe: _____

Please list any other medical information of significance, or anything else that might have a bearing on your health:

_____

_____

_____

Do you have Advanced Directives (for example, living will or durable power of attorney for health care)?

☐ Yes ☐ No If no, would you like more information? ☐ Yes ☐ No

Patient History Completed By: _____

Signature: _____Date _____

Address: _____

Emergency Contact Person: _____ Phone: _____

Reviewed by: _____Date _____