

PATIENT HEALTH UPDATE

Name _____ Birthdate _____ Date of Scheduled Visit _____

Please complete this form before your next visit to Virginia Integrative Medicine. Mail or Fax the completed form to us, at least 3 days prior to your next visit, or bring it to the visit.

Why? Our partnership to improve and maintain your health works best if we are fully informed of your concerns, symptoms, medications, supplements and other modalities of care. If you submit this to us several days prior to your visit or phone consult, it allows us the opportunity to review this information prior to your visit. This gives us a comprehensive understanding of your health needs, and allows us to make best use of your visit.

1. **Update to personal information:** (Address, Phone number, Medical insurance). Provide this information only if there are changes since your last visit.
2. **Concerns and problems to address.** (Example: Headache. Job Change. Problems with Medication)

Concern or problem	Comments
Chief concern:	
Other concerns:	

3. **Symptoms:** Please list the principal symptoms you have experienced since your last visit, old or new,

Symptom	Better or worse	When change occurred?	What makes this better or worse?

4. **Medications:** Please list all prescription and over-the-counter meds you are taking from all your physicians

Medication Name	Dose	Frequency	Comments

5. **Non-Pharmacologic Therapies:** supplements, herbs, etc. from all practitioners that you see.

Supplement Name	Dose	Frequency	Comments

6. **Health and wellness practices:** Please describe any treatments or self care practices that you do currently, such as acupuncture, yoga, meditation, physical therapy, talk therapy, etc)

Practice	Frequency	Comments

7. Review of symptoms affecting body systems: Please rate each of the following symptoms based upon how you have been feeling since your last visit. Use a point scale of 0 to 4, based on your assessment of frequency and severity of symptoms. Use "0" for never or almost never having the symptoms, with "4" indicating severe and frequent symptoms.

HEAD	<input type="checkbox"/> Headaches		LUNGS	<input type="checkbox"/> Chest Congestion	
	<input type="checkbox"/> Faintness			<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Dizziness			<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Insomnia	TOTAL _____		<input type="checkbox"/> Difficulty breathing	TOTAL _____
EYES	<input type="checkbox"/> Blurred or tunnel vision		JOINTS	<input type="checkbox"/> Pain or aches in joints	
	<input type="checkbox"/> Swollen, reddened or sticky eyelids		MUSCLE	<input type="checkbox"/> Feeling of weakness or tiredness	
	<input type="checkbox"/> Bags or dark circles under eyes			<input type="checkbox"/> Stiffness or limitation of movement	
	<input type="checkbox"/> Watery or itchy Eyes	TOTAL _____		<input type="checkbox"/> Pain or aches in muscles	
EARS	<input type="checkbox"/> Ringing in hears, hearing loss			<input type="checkbox"/> Arthritis	TOTAL _____
	<input type="checkbox"/> Earaches, ear infections		WEIGHT	<input type="checkbox"/> Binge eating/drinking	
	<input type="checkbox"/> Itchy Ears	TOTAL _____		<input type="checkbox"/> Craving certain foods	
NOSE	<input type="checkbox"/> Excessive mucus formation			<input type="checkbox"/> Excessive weight	
	<input type="checkbox"/> Sinus problems			<input type="checkbox"/> Compulsive eating	
	<input type="checkbox"/> Hay fever			<input type="checkbox"/> Water Retention	
	<input type="checkbox"/> Stuffy nose	TOTAL _____		<input type="checkbox"/> Underweight	TOTAL _____
THROAT	<input type="checkbox"/> Sore throat, hoarseness, loss of voice		ENERGY	<input type="checkbox"/> Fatigue, sluggishness	
	<input type="checkbox"/> Gagging, frequent need to clear throat			<input type="checkbox"/> Apathy, lethargy	
	<input type="checkbox"/> Swollen or discolored tongue, gums, lips			<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Chronic coughing			<input type="checkbox"/> Restlessness	TOTAL _____
	<input type="checkbox"/> Canker Sores	TOTAL _____	MIND	<input type="checkbox"/> Poor memory	
SKIN	<input type="checkbox"/> Acne			<input type="checkbox"/> Confusion, Poor Comprehension	
	<input type="checkbox"/> Hives, rashes, dry skin			<input type="checkbox"/> Poor Concentration	
	<input type="checkbox"/> Hair loss			<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Flushing, hot flashes			<input type="checkbox"/> Slurred speech	
	<input type="checkbox"/> Excessive sweating	TOTAL _____		<input type="checkbox"/> Learning disabilities	TOTAL _____
DIGESTIVE TRACT	<input type="checkbox"/> Nausea, vomiting (circle which)		EMOTIONS	<input type="checkbox"/> Mood swings	
	<input type="checkbox"/> Diarrhea			<input type="checkbox"/> Anxiety, fear, nervousness	
	<input type="checkbox"/> Constipation			<input type="checkbox"/> Anger, irritability, aggressiveness	
	<input type="checkbox"/> Bloating Feeling			<input type="checkbox"/> Depression	TOTAL _____
	<input type="checkbox"/> Belching, passing gas (circle which)		OTHER	<input type="checkbox"/> Frequent illness	
	<input type="checkbox"/> Heartburn/reflux			<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Intestinal/stomach pain	TOTAL _____		<input type="checkbox"/> Genital itch or discharge	TOTAL _____
HEART	<input type="checkbox"/> Irregular or skipped heartbeat				
	<input type="checkbox"/> Rapid or pounding heartbeat				
	<input type="checkbox"/> Chest Pain	TOTAL _____			
				GRAND TOTAL	_____