Dr. Shalini Kapoor, ND, MPH
Om Integrative Medicine

Patient Information

Patient name _____ Date _____

Guardian name, if patient is a minor _____

Address _____

City _____ State _____ Zip _____

Phone home_____Cell_____Work_____

Email _____

Emergency contact _____ Phone_____
Relationship to you _____

How did you hear about this clinic? _____

Demographics & Social history

Age:_____ Date of Birth:_____ Gender: ☐M ☐ F

☐Single ☐Married ☐Partnership ☐Separated ☐Divorced ☐Widowed

Occupation:_____Hours per week:_____
Employer:_____

Live with: ☐ Parents ☐Spouse ☐Partner ☐Alone ☐Children ☐Friends ☐Relatives

Do you have a primary care doctor? ☐ Y ☐ N
Name:_____ Location:_____ Phone:_____

What are your most important health concerns? List in order of importance to you.
1. _____ Onset?_____ Severity? (1-10)_____
2. _____ Onset?_____ Severity? (1-10)_____
3. _____ Onset?_____ Severity? (1-10)_____
4. _____ Onset?_____ Severity? (1-10)_____
5. _____ Onset?_____ Severity? (1-10)_____

Height:_____
Weight:_____ Weight 1 year ago:_____
Maximum weight:_____ When?_____

Immunization history: Please list all immunizations received and dates received:

1.
2.
3.
4.
5.
6.
7.
8.
9.

Any adverse reaction to immunizations? Please explain:

Dental History andapproximate date/year. Please check all that apply:

☐Root canal ☐Gum disease ☐ Denture
☐Multiple fillings ☐Crowns

Habits, Hobbies, and Lifestyle:

What do you love to do? What motivates you in life?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are unhealthy or self-destructive? (i.e. smoking, alcohol, coffee/caffeine, high stress)

Do you exercise? ☐ Yes ☐Past ☐Never
If yes, What kind?_____
How often?_____

Work activity ☐Sitting ☐Standing ☐Light labor ☐Heavy labor

Medications & Supplements

Do you have any known drug allergies? ☐Y ☐N

Drug	Reaction (ie. hives, rash, breathing)
_____	_____
_____	_____
_____	_____

Do you have any food, environmental or chemical allergies/sensitivities?

	Reaction (ie. hives, rash, breathing)
_____	_____
_____	_____
_____	_____

Please list any **prescriptions & over the counter medications** you take consistently. Attach additional sheet if needed.

Drug _____ Dose _____ How long?_____
Drug _____ Dose _____ How long?_____
Drug _____ Dose _____ How long?_____
Drug _____ Dose _____ How long?_____
Drug _____ Dose _____ How long?_____
Drug _____ Dose _____ How long?_____

Pharmacy name _____ Phone _____
Location _____

Please list any **supplements/herbs/homeopathy** you are currently taking

Medical History

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition, if applicable such as mother (M), father (F), sibling(S) or maternal or paternal grandmother/grandfather (MGM, MGF, PGM, or PGF).

Condition	Self	Relative	Condition	Self	Relative
Allergies			Clotting disorder		
Anemia			COPD		
Asthma			Depression		
Cancer			Diabetes		
Cataracts			Emphysema		
Congestive Heart Failure			GERD		
HIV/AIDS			Glaucoma		
Hypertension			Heart Attack		
Irritable Bowel Syndrome			Heart murmur		
Kidney Disease			Sickle_cell_anemia		
Mental disease			Stroke		
Osteoporosis			Substance Abuse		
Parkinsons/Alzheimers			Thyroid_disease		
Seizures			Tuberculosis		
Clotting disorders			Ulcers		
COPD			Other		
Depression			Other		
Seizures			Other		

Surgeries you have had and their approximate date/year. **Please check all that apply**

Appendectomy		Arteries/Veins	
Gall Bladder		Brain	
Hip		Heart	
Knee		Lung	
Shoulder		Other	
Tonsillectomy		Other	
Hysterectomy		Other	
Bowel or Liver		Other	

Review of Symptoms

Please check any of the following symptoms that you have currently:

General
☐Weight change ☐Fever ☐Chills ☐Poor sleep ☐Low energy

Head, eyes, ears, nose, throat
☐Headaches ☐Head injury ☐Jaw pain ☐Earache ☐Dizziness ☐Ringing in ears
☐Spots in vision ☐Eye pain/strain ☐Eye tearing or dryness ☐Impaired vision
☐Sinus problems ☐Frequent colds ☐ Nasal congestion/discharge ☐Allergies
☐ Difficulty swallowing ☐ Sore throat ☐Mouth sores ☐Teeth or gum problems

Respiratory
☐Shortness of breath ☐Cough ☐Asthma ☐Pain with breathing

Gastrointestinal
☐Change in bowel frequency ☐Constipation/diarrhea ☐Nausea/vomiting ☐Heartburn
☐Abdominal pain ☐Gas/bloating/belching

Urinary
☐Pain with urination ☐Increased or decreased frequency ☐ Frequent infections

Female only
☐Painful menses ☐Irregular menses ☐Hot flashes ☐Breast pain/lump/discharge

Number of pregnancies _____ Number of live birth_____
Are you on Hormone replacement therapy?:_____

Male only
☐Testicular pain/mass ☐Discharge or sores ☐Hernia ☐Sexual dysfunction ☐Prostate disease

Musculoskeletal
☐Muscle spasms ☐ Joint stiffness ☐ Chronic pain ☐Weakness ☐Pain: location_____

Blood
☐Anemia ☐Blood clot ☐Varicose veins ☐ Easy bruising ☐ Cold hands/feet

Neurological
☐ Numbness/tingling ☐Loss of balance ☐Loss of memory ☐Easily stressed

Mental/Emotional
☐Anxiety/depression ☐ Frequent worry ☐Treated for an emotional problem_____

Endocrine
☐Hypothyroid ☐Hyperthyroid ☐Blood sugar problem ☐Heat or cold intoler