

Foundation for Integrated Health



CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) What three expectations do you have from this visit to our clinic?

- What long term expectations do you have from working with our clinic?
- What expectations do you have of me personally as your physician?

2) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

3) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

4) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

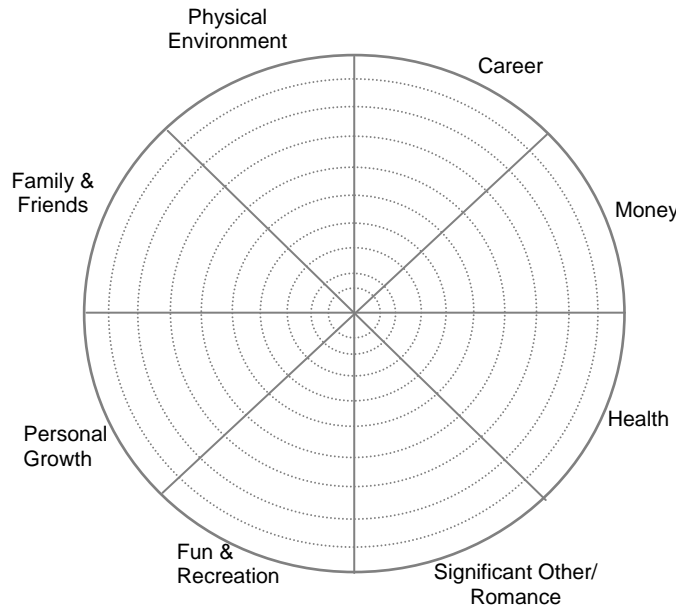
5) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wheel of Balance

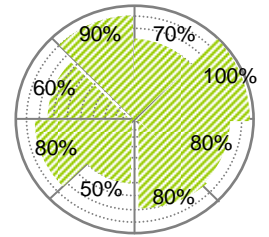
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example:



What are your most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Do you have any known contagious diseases at this time? Y N

If yes, what? _____

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum Weight : _____ When: _____

When during the day is your energy the best? _____ worst? _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y=a condition you <u>have now</u>	N=Never had	P= <u>Significant</u> problem in the past
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Habits

Main interests and hobbies? _____

Do you exercise?	Y N		
If yes, what kind?		How often?	_____
Average 6-8 hrs. sleep?	Y N	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awaken rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	Watch television?	Y N
Have a history of abuse?	Y N	Read? how many hours?	_____
Any major traumas?	Y N P	Read? how many hours?	_____
Use recreational drugs?	Y N P		
Been treated for drug dependence?	Y N P	Do you eat 3 meals a day?	Y N
Use alcoholic beverages?	Y N P	Do you go on diets often?	Y N
Treated for alcoholism?	Y N P	Do you eat out often?	Y N
Do you use tobacco?	Y N P	Do you drink coffee?	Y N P
Smoked previously?	Y N P	Drink black/green tea?	Y N P
How many years? _____		Do you drink cola/other sodas?	Y N P
How many packs per day? _____		Do you eat refined sugar?	Y N P
		Do you add salt?	Y N P

Do you have a religious or spiritual practice? Y N If yes, what? _____

Is there anything else you would like to add or comment on?