

PflegMed - Center for Integrative Medicine.
Jennifer Pflughaar, DO, ABOIM
140 W Front St Perrysburg, OH 43551

The practice of Integrative Medicine requires the understanding of clients: mind, body and spirit. Please take the time to fill out this intake form as completely as possible.

Today's Date: _____

Name: _____

Date of Birth: _____

Home Address: _____ City _____ Zip Code _____

Email address: _____

Phone Number: _____

Emergency Contact and phone number:

Goals: Please list the reasons you are here today and your goals for the visit.

Allergies: Are you aware of any drug allergies? Yes No

If Yes, please list the drugs and the reaction you had:

Environmental Allergies?

Food allergies? Food intolerances?

Medications: Please attach a separate list if you have one or need extra space.

Name	Dose	How often	Year started

Supplements: Please be as specific as possible. Please bring supplements with you to your appointment.

Name	Manufacturer	Dosage	How many times per day	Why do you take it?	Year started

Past Medical History: Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Blood clot(s) | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Breast disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Broken bone | <input type="checkbox"/> Low Testosterone |
| <input type="checkbox"/> Cancer- Type: _____ | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Chronic Pain- Where: _____ | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Reflux (GERD) |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> _____ |

Describe your health as a child: _____

General health _____ Food allergies _____

Frequent infections _____ Vaccinations _____

Mono (EBV) _____ Strep infections (PANDAS/PANS) _____

Any history of:

Amalgams (mercury fillings)? yes no

Root Canals? yes no (if yes, how many? When?) _____

Exposure to Mold? yes no (if yes, when and how long _____)

Concern for Lyme disease? yes no (if yes, when? _____)

Any implants? yes no (if yes, when, what kind? _____)
 Emotional trauma? yes no (if yes, have you gone through EMDR? _____)

Past Surgical History: List year performed next to the surgery. Fill in those not listed.

- | | |
|---|--|
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Spinal Fusion _____ |
| <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Joint Replacement _____ |
| <input type="checkbox"/> Tonsils _____ | Which joint: |
| <input type="checkbox"/> Sinus Surgery _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tubes in Ears _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hysterectomy: _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Total <input type="checkbox"/> Partial | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tubal Ligation _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cardiac Bypass _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cardiac Cath _____ | |

Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the following. (Please state the family member(s) in the space provided):

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Alzheimer's _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High cholesterol _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Bleeding disorder _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> _____ |

Preventatives screening inventory (with your Primary Care Physician, list results of last test):

Test	Year	Results
Women only: Mammogram		
Women only: Pap Smear		
Men only: PSA and digital rectal exam		
Fasting lipid panel		
DEXA/ bone density test		
Carotid doppler		
Cardiac stress test		
Colonoscopy		
Eye exam		

Social History:

Tobacco: yes no If yes, how many per day: _____ How many years: _____

Currently smoking: yes no If quit, how long ago: _____

Alcohol: yes no If yes, how many drinks per weeks: _____

Drug use (state which drug and if currently using): _____

Who lives at home with you?

How would you describe your home life? (Ex: open, loving, happy, mellow, dull, frustrating, tense, chaotic, safe, supportive, unhappy)

Please list your hobbies/interests:

Occupation- Please list what you do, how many hours a week and your level of satisfaction:

Has this or any job ever put you around strong chemicals or smoke? yes no

Spiritual Life: Having an active spiritual life or religious life if an important part of your overall health. Describe your current religious practice (Please use details: For example, do you attend church or other ceremony? Any small group studies?):

Stress: Stress and the management of stress is very important to your overall health. Describe the symptoms you feel when you are under stress and the activities or techniques you use to relieve stress:

Exercise: Frequency and type: _____

Dietary Health: Recall of dietary intake of the last 24 hours. Please list all the foods and drinks you have consumed in the previous 24 hours. (Include meals, snacks, beverages and condiments.)

Food Item	Preparation (baked, fried, ect)	Amount (cup, tbs, oz, ect)

Is this a typical day? yes no

Servings of vegetables a day _____ Servings of fruit per day _____

Caffeine intake: How many cups per day of: Coffee ____ Tea ____ Decaf Coffee/Tea ____
Soda ____ Diet soda ____ Flavored water ____ Artificial sweeteners ____

Review of Current Systems: Please check any symptoms or concerns you have had in the last several months.

Constitutional

- Good general health
- Recent weight change
- Headaches
- Fever

Ear/Nose/Throat

- Hearing loss or ringing
- Earaches or drainage
- Sinus problems
- Nosebleeds
- Bad breath or bad taste
- Goiter

Eye

- Eye disease or injury
- Wear glasses or contacts
- Glaucoma
- Double/blurred vision

Cardiovascular

- Chest pain or pressure
- Palpitations
- Shortness of breath lying flat
- Swelling of extremities

Respiratory

- Chronic or frequent cough
- Shortness of breath
- Asthma or wheezing
- Coughing up blood

Energy

- Forgetful
- Poor concentration
- Fatigue- Worst time of day: _____

Gastrointestinal

- Loss of appetite
- Nausea or vomiting
- Diarrhea
- Painful bowel movement
- Constipation
- Cramping
- Bloating
- Rectal bleeding
- Blood in stools or black stools
- Abdominal pain

Hematology

- Bleeding or bruising
- Anemia
- Past transfusion

Genitourinary

- Frequent urination
- Painful urination
- Blood in urine
- Change in force of urine
- Female - irregular menses
- Pelvic floor problems

Neurological

- Frequent headaches
(related to menses? _____)

- Light-headed/dizzy
- Numbness/tingling
- Tremors
- Head injury

Musculoskeletal

- Joint pain
- Joint stiffness/swelling
- Weak muscles or joints
- Muscle pain or cramps
- Back pain
- Difficulty in walking

Skin

- Hives
- Rash or Itching
- Varicose veins

Psychiatric

- Memory loss/Confusion
- Nervousness/Anxiety
- Depression/Mania

Breast

- Masses
- Pain/ Tenderness
- Prior abnormal mammograms

Endocrine

- Excessive thirst/urination
- Sugar cravings
- Hot/cold intolerance
- Poor sex drive
- Dry skin
- Hair loss
- PMS symptoms
- Post-menopausal bleeding

Sleep

- Problems falling asleep
- Problems staying asleep
- Snoring
- Restless legs

Menstrual and Pregnancy History (women only):

Number of pregnancies ___ Live births ___ Living children ___ Abortions ___ Miscarriages ___
 ___ Last Menstrual Period _____ Last pelvis and PAP exam _____ Last mammogram _____
 Are your periods normal ___ How long are they? ___ days Abnormal regularity ___
 Abnormal flow ___ Abnormal pain ___ List all forms of birth control _____

Sleep Inventory:

Are you satisfied with the quality and quantity of your sleep? yes no
 Do you wake up in the middle of the night? yes no At what time? _____
 Are you able to go back to sleep if you wake up? yes no
 Are you tired or sleepy during the day? yes no
 Do you snore? yes no

Previous Complimentary Experience:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation |
| <input type="checkbox"/> Breathwork | <input type="checkbox"/> Naturopathy |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Qi Gong |
| <input type="checkbox"/> Guided Imagery | <input type="checkbox"/> Reflexology |
| <input type="checkbox"/> Homeopathy | <input type="checkbox"/> Reiki |
| <input type="checkbox"/> Hypnotherapy | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Iridology | |

Please list anything you would like to discuss today:
