PflegMed – Center for Integrative Medicine.
Jennifer Pfleghaar, DO, ABOIM & Amanda Mosher, CNP
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:

____

Preferred Pharmacy (regular and compounding): _________________________________

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

____

____

____

When did you first notice your complaints? If you could write out a timeline that would be helpful! ____

____

____

____

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

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

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, silver fillings)? □ yes □ no
Root Canals? □ yes □ no (if yes, how many? When?) ________________________
Exposure to Mold? (did you ever live in a moldy home, dorm, apartment? □ yes □ no
(if yes, when and how long __________________)
Concern for Lyme disease? (tick bite, rash) □ 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? __________)
Traumatic life events? □ yes □ no (if yes, when: ______________________)
COVID: Have you had it? □ yes □ no or where you vaccinated? □ yes □ no
→When? _________ Did any of your complaints start around this time? □ yes □ no

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

□ Appendix ____________
□ Gallbladder __________
□ Tonsils ______________
□ Sinus Surgery ________
□ Tubes in Ears _________
□ Hysterectomy: ________
□Total □ Partial
□ Tubal Ligation _________
□ Cardiac Bypass ________
□ Cardiac Cath __________

□ Spinal Fusion __________
□ Joint Replacement ______
Which joint:
□ ______________________
□ ______________________
□ ______________________
□ ______________________
□ ______________________
□ ______________________

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):

□ Alcoholism __________
□ Allergies ___________
□ Alzheimer's __________
□ Anemia ______________
□ Asthma ______________
□ Bleeding disorder ______
□ Cancer _______________
□ Depression ___________
□ Diabetes ______________

□ Epilepsy ______________
□ Heart disease ___________
□ High blood pressure_______
□ High cholesterol _________
□ Kidney Disease __________
□ Stroke _________________
□ _____________________
□ _____________________
□ _____________________

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 or pick a normal day.
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
- □ 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
□ Hot flashes

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 ____ Menopause year ____
Are your periods normal ___ How long are they? (28, 29 30) ___ days in total
Abnormal flow __ Abnormal pain __ List all forms of birth control ____________
Are you looking to getting pregnant in the next few years? ______________

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
Have you had a sleep study before? □ yes □ no If yes, results: __________________

Previous Complimentary Experience:

- ☐ Acupuncture
- ☐ Biofeedback
- ☐ Breathwork
- ☐ Chiropractic
- ☐ Guided Imagery
- ☐ Homeopathy
- ☐ Hypnotherapy
- ☐ Iridology
- ☐ Massage
- ☐ Meditation
- ☐ Naturopathy
- ☐ Qi Gong
- ☐ Reflexology
- ☐ Reiki
- ☐ Yoga

What things have you tried already for your specific complaints (conventional or alternative)? Please include or bring previous labwork, functional testing, ect.

____
____
____
____

Please list anything you would like to discuss today:

____
____
____
____