GW Center for Integrative Medicine
908 New Hampshire Ave NW, Ste 200
Washington, Washington, D.C., US - 20037

GWCIM New Patient Adult PHI

GW Center for Integrative Medicine
908 New Hampshire Avenue, NW, Suite 200, Washington, DC 20037

Patient Health Inventory

Please allow adequate time to complete the inventory as thoroughly as possible. All information is voluntary, confidential and for the sole purpose of evaluation and/or treatment assessment by certified and credentialed practitioners within the Center for Integrative Medicine.

Context of Care Review

Successful heath care and preventive medicine are only possible when the physician has a complete understanding if the patient is well physically, mentally, and emotionally. The nature of your response to the following questions will go a long 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.

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

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Smoking Status

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker
☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

What are your pronouns?

☐ he/him ☐ she/her ☐ they/them

How did you hear about us (please be specific)?

☐ Referred by a physician ☐ Referred by CIM practitioner ☐ Referred by a CIM patient
☐ Word of mouth ☐ Online engine search ☐ AANP Naturopathic website/directory
☐ Other professional website/directory

If referred by another health care provider, would you like the practitioners at GWCIM to communicate with those providers?

☐ No ☐ Yes

Provider/s: name, contact information

Main reason(s) for office visit:

Are you interested to work with a specific GWCIM provider? List their name(s).

Who is your primary care provider? Please list name and phone number.

Primary Contact Details

Caregiver First Name _____

Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Vaccination History

Have you been routinely vaccinated as a child? ☐ Yes ☐ No

As an adult have you received all vaccines and boosters recommended by your health care provider? ☐ Yes ☐ No

Have you received COVID19 vaccine? Describe which type, when and how many doses.

Primary Insurance Details

Insurance Type *

☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS
☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG
☐ OTHER

Insurance Plan Name or Program Name *

ID *

Insurance Company Name (Payer Name) *

Payer Id *

Payer Address

Payer City

Payer Country

Payer State

Payer ZipCode

Valid From

Valid Until

Policy Group/FECA #

Copay

Deductible

Employer/School Name

Comments

Insured Person Details

Patient Relationship *

☐ Self ☐ Spouse ☐ Child
☐ Other

First Name *

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TOGETHER WE CARE, HEAL, EDUCATE

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Last Name *

Date of Birth *

Sex * ☐ Male ☐ Female ☐ Unknown

Address Line 1

Address Line 2

City

Country

State

Zip Code

Home Phone

Mobile Phone

History of Present Illness

Please describe the current condition or illnesses for which you are seeking treatment at the Center. Please include the dates when the illness began.

This condition interferes with: ☐ Work ☐ Sleep ☐ Exercise ☐ Social Life

This condition is getting: ☐ Worse ☐ Better ☐ Staying the same

What do you believe is the cause?

How is this condition being treated?

Have you tried these treatments? Did you find them helpful? Are you interested in any new treatments to try?

☐ Conventional Medicine
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Naturopathic Medicine
- ☐ Tried

- ☐ Found helpful
- ☐ Interested

☐ Acupuncture
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Chiropractic
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Herbal Medicine (Western, Chinese, Aurvedic)
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Cannabis
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Nutritional Counseling
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Alexander Technique
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Mind-Body Medicine
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Hypnotherapy
- ☐ Tried
- ☐ Found helpful
- ☐ Interested

☐ Meditation, Mindfulness Practices
- ☐ Tried
- ☐ Found helpful

- ☐ Interested

- ☐ Reiki
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested
- ☐ Rolfing
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested
- ☐ Yoga
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested
- ☐ Massage Therapy
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested
- ☐ Spiritual Direction
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested
- ☐ Homeopathy
  - ☐ Tried
  - ☐ Found helpful
  - ☐ Interested

Please list other health conserns:

☐ Other _____

Please tell us your goals and expectation for treatment at GW Center:

Childhood/Family/Past History

Where were you born? _____

Was your birth: ☐ Normal ☐ Premature ☐ Long Labor ☐ Complications

Were there any developmental issues?

Did you experience significant trauma, life and/or health-threatening events in your childhood?

☐ yes ☐ no ☐ not sure
☐ interested to discuss with a provider

How would you characterize your family life growing up?

Were you adopted? If yes, at what age?

Father

If living: age and health:

If deceased: age, year, and cause of death:

Mother

If living: age and health:

If deceased: age, year, and cause of death:

Do you have any siblings? List.

Did you have any serious health issues in past?

List major surgeries

Are you interested in filling out ACEs (advert childhood experiences) form if recommended by your provider?

☐ yes ☐ no ☐ maybe

Nutrition History

Weight:

Height

Weight one year ago:

Have you experienced sudden weight loss or gain? When?

Food allergies or sensitivities?

Do you adhere to any specific diet - for health, weight loss, ethical or other reasons? Please, specify.

Please list what you eat during a typical day and at what time:

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you practice fasting?

Do you use caffeine products (soda, coffee, tea, etc)?

☐ never ☐ occasionally ☐ daily once
☐ daily multiple times

Depend on coffee to keep yourself going or started?

☐ Yes ☐ No

What foods/drinks do you regularly crave?

Are there any foods you avoid because they don't agree with your digestion?

Do you cook for yourself/your family?

☐ Yes ☐ No

What portion of your food is organic? ☐ most ☐ some ☐ none

Environmental Exposures

Have you ever lived near a refinery, polluted area or in a home with leaded paint? ☐ yes ☐ no ☐ no sure

If yes, what sort of pollution where you exposed to?

Have you ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect your health?

Do you seem particularly sensitive to ro perfumes, gasoline or other vapors? ☐ Yes ☐ No

Do you spray pesticides, herbicides or other chemicals around your home? ☐ Yes ☐ No

What year was your home/apartment built? _____

Do you have H20 Purification System at home? ☐ Yes ☐ No

Air Purifiers: ☐ Yes ☐ No

Type of Heat: ☐ Gas ☐ Electric

Do you live near any bodies of water? ☐ Swamp ☐ Creek ☐ River ☐ Ocean ☐ None

Do you live near any of the following: ☐ High Voltage Power Lines ☐ Refinery ☐ Woods ☐ Industrial area

Describe your bedroom (curtains, blinds, carpet, feather pillows, etc)

Flooring in other rooms you spend time in:

Please list any other concerns or comments:

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Health Overview

For the following section, please read the question and select from the following responses: Yes, No, or In Past. If No, move on to the next question. If Yes or In past, please specify the severity in the "Others" box, choosing from the following: Mild, Moderate, or Severe.

Endocrine

Do you sleep well?	☐ Yes	☐ No	☐ In Past
Average 6-8 hours?	☐ Yes	☐ No	☐ In Past
Awake rested?	☐ Yes	☐ No	☐ In Past
Cannot stay asleep?	☐ Yes	☐ No	☐ In Past
Cannot fall asleep?	☐ Yes	☐ No	☐ In Past
Insomnia?	☐ Yes	☐ No	☐ In Past
Do you nap during the day?	☐ Yes	☐ No	☐ In Past
Afternoon Fatigue?	☐ Yes	☐ No	☐ In Past
Wake up tired even after 6 or more hours of sleep?	☐ Yes	☐ No	☐ In Past
Tired or sluggish?	☐ Yes	☐ No	☐ In Past
Dizziness when standing up quickly?	☐ Yes	☐ No	☐ In Past
Hyperthyroid/Hypothyroid?	☐ Yes	☐ No	☐ In Past
Hypoglycemia?	☐ Yes	☐ No	☐ In Past
Difficulty losing weight?	☐ Yes	☐ No	☐ In Past
Gain weight easily?	☐ Yes	☐ No	☐ In Past
Feel cold - hands, feet, all over?	☐ Yes	☐ No	☐ In Past
Thinning of hair on scalp, face, or genitals or excessive falling hair?	☐ Yes	☐ No	☐ In Past
Have facial hair growth (women), acne or or unusual skin discoloration?	☐ Yes	☐ No	☐ In the past

Neurologic

Seizures?	☐ Yes	☐ No	☐ In Past
Muscle weakness?	☐ Yes	☐ No	☐ In Past
Loss of memory	☐ Yes	☐ No	☐ In Past
Vertigo or dizziness?	☐ Yes	☐ No	☐ In Past
Paralysis?	☐ Yes	☐ No	☐ In Past
Numbness or Tingling?	☐ Yes	☐ No	☐ In Past
Easily Stressed?	☐ Yes	☐ No	☐ In Past
Loss of balance?	☐ Yes	☐ No	☐ In Past

Neck

Pain or stiffness in neck?	☐ Yes	☐ No	☐ In Past
Difficulty swallowing?	☐ Yes	☐ No	☐ In Past
Lumps in neck?	☐ Yes	☐ No	☐ In Past
Goiter?	☐ Yes	☐ No	☐ In Past

Immune

Reactions to immunizations?	☐ Yes	☐ No	☐ In Past
Chronically swollen glands?	☐ Yes	☐ No	☐ In Past
Slow would healing?	☐ Yes	☐ No	☐ In Past
Chronic fatigue syndrome?	☐ Yes	☐ No	☐ In Past
Chronic infections?	☐ Yes	☐ No	☐ In Past
Night sweats?	☐ Yes	☐ No	☐ In Past

Ears

Ringing in ears?	☐ Yes	☐ No	☐ In Past
Ear aches?	☐ Yes	☐ No	☐ In Past
Impaired hearing?	☐ Yes	☐ No	☐ In Past

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Eyes

Impaired vision?	☐ Yes	☐ No	☐ In Past
Cataracts?	☐ Yes	☐ No	☐ In Past
Glaucoma?	☐ Yes	☐ No	☐ In Past
Tearing or dryness?	☐ Yes	☐ No	☐ In Past
Spots in vision?	☐ Yes	☐ No	☐ In Past

Head

Headaches?	☐ Yes	☐ No	☐ In Past
Migraines?	☐ Yes	☐ No	☐ In Past
Head injury?	☐ Yes	☐ No	☐ In Past
Jaw or TMJ problems?	☐ Yes	☐ No	☐ In Past

Nose and Sinus

Stuffiness?	☐ Yes	☐ No	☐ In Past
Sinus problems?	☐ Yes	☐ No	☐ In Past
Nose bleeds?	☐ Yes	☐ No	☐ In Past
Hay fever?	☐ Yes	☐ No	☐ In Past
Loss of smell?	☐ Yes	☐ No	☐ In Past

Mouth and Throat

Teeth grinding?	☐ Yes	☐ No	☐ In Past
Gum problems?	☐ Yes	☐ No	☐ In Past
Jaw clicking?	☐ Yes	☐ No	☐ In Past
Frequent sore throat?	☐ Yes	☐ No	☐ In Past
Sore tongue or lips?	☐ Yes	☐ No	☐ In Past
Hoarseness?	☐ Yes	☐ No	☐ In Past

Number of cavities/fillings? _____

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Do you have any amalgam/silver fillings? How many?	☐ Yes ☐ No		

Skin

Eczema or hives?	☐ Yes	☐ No	☐ In Past
Dry or flaky skin and/or scalp?	☐ Yes	☐ No	☐ In Past
Itching?	☐ Yes	☐ No	☐ In Past
Rashes?	☐ Yes	☐ No	☐ In Past
Acne/boils?	☐ Yes	☐ No	☐ In Past
Change in skin color?	☐ Yes	☐ No	☐ In Past
Lumps or bumps on skin?	☐ Yes	☐ No	☐ In Past
Excessive hair loss?	☐ Yes	☐ No	☐ In Past
Weak nails?	☐ Yes	☐ No	☐ In Past

Cardiac and Respiratory

Do you have abnormal blood pressure	☐ normal ☐ variable	☐ high	☐ low
Shortness of breath?	☐ Yes	☐ No	☐ In Past
Chest pain?	☐ Yes	☐ No	☐ In Past
Cough?	☐ Yes	☐ No	☐ In Past
Asthma?	☐ Yes	☐ No	☐ In Past
COPD?	☐ Yes	☐ No	☐ In Past
Shortness of breath when lying down?	☐ Yes	☐ No	☐ In Past
Heart palpitations?	☐ Yes	☐ No	☐ In Past
How do you tolerate physical activity?	☐ feel great after ☐ get exhausted	☐ well ☐ can't tolerate any	☐ get tired easily

Musculoskeletal

Scoliosis?	☐ Yes ☐ No		
Muscle spasms or cramps?	☐ Yes	☐ No	☐ In Past

Joint pain or stiffness?	☐ Yes	☐ No	☐ In Past
Arthritis?	☐ Yes	☐ No	☐ In Past
Broken bones?	☐ Yes	☐ No	☐ In Past
Osteoporosis?	☐ Yes	☐ No	☐ In past

Blood

Varicose veins?	☐ Yes	☐ No	☐ In Past
Anemia?	☐ Yes	☐ No	☐ In Past
Easy bleeding or bruising?	☐ Yes	☐ No	☐ In Past
Cold hands/feet?	☐ Yes	☐ No	☐ In Past
Swollen ankles?	☐ Yes ☐ No		

Gastrointestinal

Change in thirst?	☐ Yes	☐ No	☐ In Past
Change in appetite?	☐ Yes	☐ No	☐ In Past
Specific foods can cause distress?	☐ Yes	☐ No	☐ In Past
Indigestion and fullness lasts 2-4 hours after eating?	☐ Yes	☐ No	☐ In Past
Heartburn?	☐ Yes	☐ No	☐ In Past
Abdominal pain or cramps?	☐ Yes	☐ No	☐ In Past
Excessive belching, burping, or bloating?	☐ Yes	☐ No	☐ In Past
Gas immediately following meals?	☐ Yes	☐ No	☐ In Past
Use antacids?	☐ Yes	☐ No	☐ In Past
Unplesant breath?	☐ Yes	☐ No	☐ In Past
History of gallbladder disease?	☐ Yes	☐ No	☐ In Past
Have you had your gallbladder removed?	☐ Yes ☐ No		
Liver disease?	☐ Yes	☐ No	☐ In Past
Hemorrhoids?	☐ Yes	☐ No	☐ In Past

Pancreatitis?	☐ Yes	☐ No	☐ In Past
Diarrhea?	☐ Yes	☐ No	☐ In Past
Constipation?	☐ Yes	☐ No	☐ In Past
Alternating diarrhea and constipation?	☐ Yes	☐ No	☐ In Past
Blood in stools?	☐ Yes	☐ No	☐ In Past
Use laxatives frequently?	☐ Yes	☐ No	☐ In Past

Mental/Emotional

Treated for mental or psychological problems?	☐ Yes	☐ No	☐ In Past
Have you ever been in a relationship that has been physical or mentally hurtful?	☐ Yes	☐ No	☐ In Past
Depression?	☐ Yes	☐ No	☐ In Past
Anxiety or nervousness?	☐ Yes	☐ No	☐ In Past
Poor concentration?	☐ Yes	☐ No	☐ In Past
Poor memory?	☐ Yes	☐ No I	☐ In Past
Mood swings?	☐ Yes	☐ No	☐ In Past
Have you considered physically harming yourself?	☐ Yes ☐ No		
Considered suicide?	☐ Yes	☐ No	☐ In Past
Attempted suicide?	☐ Yes	☐ No	☐ In Past
Treated for drug, alcohol or other dependence?	☐ Yes	☐ No	☐ In Past
Behavioral concerns?	☐ Yes	☐ No	☐ In Past
Sexuality concerns?	☐ Yes	☐ No	☐ In Past
Self esteem/ growth issues?	☐ Yes	☐ No	☐ In Past
Mental sluggishness?	☐ Yes	☐ No	☐ In Past

Urinary

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Increased frequency of urination?	☐ Yes	☐ No	☐ In Past
Inability to hold urine?	☐ Yes	☐ No	☐ In Past
Painful urination?	☐ Yes	☐ No	☐ In Past
Frequency at night?	☐ Yes	☐ No	☐ In Past
Frequent urinary tract infections?	☐ Yes	☐ No	☐ In Past
Kidney stones?	☐ Yes	☐ No	☐ In Past

Female Reproductive

Age of first menses?	_____
Date of last menses?	_____
Length of cycle (in days)	_____
Duration of menses (in days)	_____

Are your cycles regular?	☐ Yes	☐ No	☐ In Past
Bleeding between cycles?	☐ Yes	☐ No	☐ In Past
Clotting?	☐ Yes	☐ No	☐ In Past
Scanty blood flow?	☐ Yes	☐ No	☐ In Past
Heavy blood flow?	☐ Yes	☐ No	☐ In Past
Pain and cramping during periods?	☐ Yes	☐ No	☐ In Past
Pelvic pain during menses?	☐ Yes	☐ No	☐ In Past
Irritable and depressed during menses?	☐ Yes	☐ No	☐ In Past
Acne breakouts?	☐ Yes	☐ No	☐ In Past
Facial hair growth?	☐ Yes	☐ No	☐ In Past
Endometriosis/fibroids/ovarian cysts?	☐ Yes	☐ No	☐ In Past
Vaginal discharge?	☐ Yes	☐ No	☐ In Past
Abnormal PAP?	☐ Yes	☐ No	☐ In Past
Are you in sexual relationship?	☐ Yes	☐ No	☐ In past

Your sexual orientation	☐ heterosexual	☐ homosexual	☐ bisexual
	☐ queer	☐ asexual	
Changes in sex drive?	☐ Yes	☐ No	☐ In Past
History of sexually transmitted infection?	☐ Yes	☐ No	
Birth control (oral contraceptives, IUD, vasectomy, diaphragm, cervical cap, vaginal ring, patch, shot, etc? (if yes or in past, please specify in "other")	☐ Yes	☐ No	☐ In Past
Difficulty conceiving?	☐ Yes	☐ No	☐ In Past
Number of pregnancies?	_____		
Number of live births?	_____		
Number of miscarriages?	_____		
Number of therapeutic abortions?	_____		
Regular mammograms if applicable? Please specify date of last mammogram in "other"	☐ Yes	☐ No	
Do you do self breast exams?	☐ Yes	☐ No	☐ In Past
Breast pain/tenderness?	☐ Yes	☐ No	☐ In Past
Breast lumps?	☐ Yes	☐ No	☐ In Past
Nipple discharge?	☐ Yes	☐ No	☐ In Past
Menopausal symptoms?	☐ Yes	☐ No	☐ In Past
Other symptoms?			

Male Reproductive

Are you in sexual relationship?	☐ Yes	☐ No	☐ In Past
Sexual orientation?	☐ heterosexual	☐ homosexual	☐ bisexual
	☐ queer	☐ asexual	
History of STD?	☐ Yes	☐ No	☐ In Past

Changes in sex drive?	☐ Yes	☐ No	☐ In Past
Decrease in spontaneous morning erections?	☐ Yes	☐ No	☐ In Past
Decrease in fullness of erections?	☐ Yes	☐ No	☐ In Past
Premature ejaculation?	☐ Yes	☐ No	☐ In Past
Inability or difficulty to achieve and maintain erection?	☐ Yes	☐ No	☐ In Past
Discharge or sores?	☐ Yes	☐ No	☐ In Past
Testicular pain?	☐ Yes	☐ No	☐ In Past
Prostate disease?	☐ Yes	☐ No	☐ In Past
Hernias?	☐ Yes	☐ No	☐ In Past

Please list any other concerns or questions for us.