Vista Family Health Center
3569 Round Barn Circle, Santa Rosa, CA 95404
Ph: (707) 303-3600 Fax: (707) 303-3611

Hello and Welcome to Integrative Medicine Clinic at Vista!

You are receiving this letter because your primary care provider **referred you to our consult clinic**. He/she feels that you have health goals or a medical condition that can be addressed effectively using an integrative medicine approach.

Integrative medicine takes a holistic approach focusing on you and your life and then uses nutrition, movement, relaxation skills, herbs, supplements and other healing traditions to help you move towards your goals. **Please fill out the paperwork as best you can** because understanding you better as a person **helps us to find solutions**.

We serve as consultants to you and your provider; therefore, we do not typically see patients on a continuous basis. However, if your provider has any questions about our recommendation, we are more than happy to review them with him/her.

What to expect:

- More Comfortable Environment: We will meet in a larger room with water and tea available.
- Team Based Care: We believe in the benefits of team-based care. The care team may include other doctors, pharmacists, medical students, or health care workers.
- Concrete Steps: You can expect to leave with a plan to meet your health goals.
- Longer Visit: You can expect that the visit will also be longer than what you are used to, about 40 minutes.

We look forward to your visit!

Sincerely,

The Vista Clinic Integrative Medicine Team

Patient Intake Questionnaire

name: date:

Magic Wand

imagine you had a magic wand and could change three things about yourself and your life.

What would they be?

1.

2.

3.

Symptoms

What 3 symptoms are most bothersome?

Strengths/Resources

(examples: What do you have in your life or do for yourself that really helps you? Is there anythings you worked hard for and succeeded at? Is there anything you are most proud of?)

Time Line: What major events have happened in your life?

Above Line

- When you last felt well?
- When each specific symptom began
- How symptoms have changed
- Anything else you think is important

Below line events

- major events (deaths, births, injuries, divorces, children, other).
- Anything else you think is important

Average Day

Sleep	Food and Drinks	Movement	Stress
What time do you go to bed? How long does it take you to get to sleep? How often do you wake up and why? How many hours are you in bed? How many hours are you sleeping? Rate your satisfaction with your sleep *Poor Good Great*	How soon after you wake do you have your first food? How many times do you eat during the day? B: L: D: snacks: How many servings of vegetables a day? Rate your satisfaction with what you eat *Poor Good Great*	How much do you move during the day? Do you have any formal exercise program? Rate your satisfaction with your movement? *Poor Good Great*	Rate your stress? *Low Moderate High* What are your main sources of stress? What do you do to relax? How often do you do it? Does it work?

Provider Use Only

Habits: Tobacco / alcohol / caffeine / MJ / other

PMHx:

Meds/Supplements:

What do you do during the day? (example: I wake up at _____ and then I _____, and then I usually _____, and then I usually _____... and then I go to bed at __)

What do you do for fun/pleasure/relaxation?

Who do you live with or spend time with regularly?

What brings you a sense of fulfillment?

Do you have a spiritual practice?
If yes, please describe: