# Schneck Integrative Medicine

## Dr. Steve Windley / Sherry Arbuckle FNP-C

 Please arrive at least 20 minutes before your appointment for check-in. While we will do our best to accommodate you, arriving late may require us to reschedule your appointment.

 If you need to reschedule, kindly provide at least one business days' notice.

 Remember to bring your insurance cards and a photo ID.

 Please complete the new patient paperwork before your visit. If you are unable to complete it in advance, please arrive 40 minutes early to allow enough time.

 If you have lab results, you may send them to us prior to your appointment. You can fax them to the provider at (812) 523-5869 or submit them through the Schneck Medical Center patient portal. If you need assistance with the portal please call our office (812)523-5865 and a member of our team would be happy to assist you.

 Additionally, please create a list of goals for your visit, as the provider will discuss these with you at the beginning of your appointment.

# New Patient Intake Form

Please complete all applicable sections. This form is used for all new patients.

## Patient Information

Full Name: ______________________________________________

Date of Birth: ______________________________________________

Phone Number: ______________________________________________

Email Address: ______________________________________________

Primary Care Provider (if applicable): ________________________________

***(DR WINDLEY/SHERRY ARE NOT A PRIMARY CARE DOCTOR)***

## Primary Concerns & Goals

What brings you in today? ___________________________________________________

How long have you experienced this? __________________________________________

How frequent and severe are your symptoms?___________________________________

What makes your symptoms worse? __________________________________________

What makes your symptoms better? __________________________________________

How do your symptoms interfere with your daily life, family life and career?____________

______________________________________________________________________________

______________________________________________________________________________

Top health goals (1–3): ______________________________________________________

## Medications & Supplements

| Medication / Supplement | Dose | Frequency |
|---|---|---|
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| | | |
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| | | |
| | | |
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| | | |
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| | | |
| If you need additional space to list your medications or supplements, please use a separate form. | | |

## Pharmacy

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## Allergies

List all known allergies and reactions:

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## Personal Safety

Physical Abuse? ☐ Yes ☐ No
Emotional Abuse? ☐ Yes ☐ No
Sexual Abuse? ☐ Yes ☐ No

## Communication

Primary Language:
_______________________
Preferred Language:
_______________________

Interpreter Required? ☐ Yes ☐ No
Able to Read? ☐ Yes ☐ No
Able to Write? ☐ Yes ☐ No
Learns Best By (check all that apply):
☐ Hearing ☐ Seeing ☐ Doing ☐ Unable
Barriers to Learning (check all that apply):
☐ None ☐ Visual ☐ Auditory ☐ Reading ☐ Cognitive/Verbal ☐ Cognitive/Written ☐ Motivation ☐ Physical ☐ Age-related
☐ Language ☐ Energy Level ☐ Emotional ☐ Cultural ☐ Religious ☐ Financial ☐ Confusion ☐ Developmental delay
Communication Tools (check all that apply):
☐ Facial Expression ☐ Letter Board ☐ Picture Board ☐ Gestures ☐ Writing Tablet ☐ Sign Language
☐ Lip Reading ☐ Interpreter
☐ Large Print ☐ Braille ☐ Amplifier ☐ Electronic Equipment

## US Military History

Military Service? ☐ Yes ☐ No

## Education

Highest Level of Education Completed (check one):
☐ Never attended / Kindergarten
☐ 1st–8th Grade
☐ Some High School
☐ High School Graduate
☐ GED / Equivalent
☐ Some College
☐ Associate Degree
☐ Bachelor's Degree
☐ Master's Degree

☐ Professional Degree
☐ Doctoral Degree
☐ Decline to Answer
☐ Don't Know

## Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
Trouble falling or staying asleep, or sleeping too much
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling tired or having little energy
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Poor appetite or overeating
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling bad about yourself — or that you are a failure or have let yourself or your family down
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Trouble concentrating on things such as reading or watching television
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Moving or speaking so slowly that other people could have noticed, or being fidgety or restless
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Thoughts that you would be better off dead or of hurting yourself in some way
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

PHQ-9 Total Score: _______________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

## Generalized Anxiety Disorder (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious, or on edge
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Not being able to stop or control worrying
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Worrying too much about different things
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Trouble relaxing
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Being so restless that it is hard to sit still
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Becoming easily annoyed or irritable
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling afraid as if something awful might happen
☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

GAD-7 Total Score: _______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

## Previous Treatments & Medical History

Please list treatments you have received so far. Include tests, medications, procedures, therapies, and consultations.

_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Have any of these treatments helped? Please explain.

_______________________________________________________________
_______________________________________________________________

Were there any complications, side effects, or adverse reactions related to previous treatments?

_______________________________________________________________
_______________________________________________________________

## Social & Living Situation

Who lives at home besides you?

__________________________________________________

Are they healthy?

__________________________________________________

Marital Status: __________________ Number of Children: ________________

## Previous Medical History

Please check any conditions that apply to you:

☐ Hypothyroidism
☐ Chronic Fatigue
☐ Fibromyalgia
☐ Hypoglycemia
☐ Irritable Bowel Syndrome
☐ High Cholesterol

☐ High Blood Pressure
☐ Macular Degeneration
☐ Coronary Artery Disease / Heart Disease
☐ Heart Attack
☐ Stroke
☐ Diabetes – Age at diagnosis: ________________
☐ Arthritis – Where are you affected?
_________________________________________________
☐ Other medical conditions:
_________________________________________________

## Surgical History

Please check all that apply:
☐ Adenoid Removal
☐ Sinus Surgery
☐ Tubes in Ears
☐ Cataracts
☐ Tonsils
☐ Gallbladder Removal
☐ Hysterectomy
☐ Appendix Removal
☐ Ovary Removal
☐ Joint Replacement – Which joints?
_________________________________________________
☐ Other surgeries:
_________________________________________________

Blood Type: ________________

## Family Medical History

Please check all the appropriate boxes for each family member if any of the following apply.

| Condition | Mother | Father | Grandmother | Grandfather | Siblings | Children |
|---|---|---|---|---|---|---|
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

If yes to cancer, please list type of cancer and age at diagnosis:
_________________________________________________
_________________________________________________

## Tobacco Use

Tobacco Status (check one):
☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Smoker, status unknown ☐ Unknown if ever smoked ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Vape
Nicotine-containing products used (check all that apply):
☐ E-cigarettes ☐ Vaping products ☐ Smokeless tobacco ☐ Other
Nicotine product details:
______________________________

Tobacco use type (check all that apply):
☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Vape ☐ Dipping tobacco ☐ Chewing tobacco ☐ Snuff ☐ Tobacco gum ☐ E-cigarettes ☐ Other
Smoking history (pack years):
☐ <10 ☐ 10–25 ☐ 25–50 ☐ >50
Second-hand smoke exposure? ☐ Yes ☐ No
Quit status (if applicable): ☐ Considering quitting ☐ Not considering quitting

## Alcohol Use – AUDIT-C

Within the past year, how often did you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2–4 times a month ☐ 2–3 times a week ☐ 4 or more times a week
Within the past year, how many standard drinks did you have on a typical day?
☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more
Within the past year, how often did you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
AUDIT-C Total Score:
________
Score Interpretation:
______________________________

## Drugs / Non-Prescribed Substance Use

Non-prescribed substance use (check all that apply):
☐ Denies use ☐ Former substance user ☐ Cannabis ☐ Crack/Cocaine ☐ Amphetamines/Methamphetamines
☐ Sedatives/Tranquilizers ☐ Opioids/Painkillers ☐ Club/Designer drugs ☐ OTC misuse ☐ Declined to answer ☐ Other
Counseling provided (check all that apply):
☐ None ☐ Provider counseling ☐ Reduce to 2 or fewer per day ☐ Support program ☐ Other
Substance use details:
______________________________

## Energy / Activity

☐ Fatigue ☐ Weight gain ☐ Weight loss ☐ Put on weight easily ☐ Feel cold at temperatures others find comfortable ☐ Insomnia ☐ Heat intolerance ☐ Sweating ☐ Fever ☐ Night sweats

Does going without food make you irritable or lightheaded? ☐ Yes ☐ No
Time of day you feel best: __________ Worst: __________
Amount of exercise per week: ________________________________

## Eyes

☐Blurred vision ☐ Eye irritation ☐ Vision loss ☐ Corrective lenses ☐ Eye pain ☐ Dry eye ☐ Spots in vision ☐ Double vision ☐ Cataracts ☐ Macular degeneration

## Mouth, Throat & Ears

☐Ear pain ☐ Stuffy nose ☐ Canker sores ☐ Hearing loss ☐ Nose bleeds ☐ Oral lesions ☐ Tinnitus (ringing in ears) ☐ Post-nasal drainage ☐ Hoarseness ☐ Vertigo ☐ Bleeding gums ☐ Sore throat ☐ Runny nose ☐ Dental pain ☐ Mouth breathing ☐ Bad breath ☐ Ear infections ☐ Hay fever ☐ Dizziness ☐ Dental infections
Number of root canals: __________ ☐ Silver fillings

## Cardiovascular

☐ Chest pain ☐ Orthopnea ☐ Leg pain with walking ☐ Decreased exercise tolerance ☐ Heart palpitations ☐ Leg ulcers ☐ Shortness of breath with activity ☐ Fainting/passing out ☐ Edema ☐ Hypertension ☐ Rapid heartbeat ☐ Irregular heartbeat ☐ Varicose veins ☐ Snoring while sleeping ☐ Mitral valve prolapse ☐ Swollen feet

## Lungs

☐ Cough ☐ Mucus production ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Snoring ☐ Apneas ☐ Asthma ☐ Bronchitis ☐ Difficulty breathing
☐ Ever had a chest X-ray

## Digestive Tract

☐Abdominal pain ☐ Bloating ☐ Belching ☐ Food intolerance ☐ Nausea ☐ Vomiting ☐ Swallowing difficulties ☐ Reflux/heartburn ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Black stools ☐ Bloody stools ☐ Poor sense of taste ☐ Hemorrhoids

## Urinary Tract / Bladder

☐ Change in urinary stream ☐ Painful urination ☐ Blood in urine ☐ Inability to control urination ☐ Urination at night ☐ Frequent urination ☐ Urination urgency ☐ Painful menstruation ☐ Painful intercourse ☐ Postmenopausal ☐ Low libido ☐ Vaginal discharge ☐ Kidney/bladder infections

## Joints / Muscles

☐ Joint pain ☐ Loss of muscle ☐ Muscle cramps ☐ Muscle aches ☐ Joint swelling

## Skin

☐Hair changes ☐ Lesions ☐ Nail changes ☐ Skin discoloration ☐ Itching skin ☐ Rash ☐ Cold ha nds ☐ Cold feet ☐ Dry skin ☐ Hives ☐ Psoriasis ☐ Acne ☐ Loss of hair ☐ Facial puffiness in mornings ☐ Weak/brittle nails ☐ Itching ☐ Dry, coarse, brittle hair

## Head

☐ Change in walking patterns ☐ Body weakness ☐ Headaches
Headache location: ___________________________________
☐ Migraines   Frequency: ______________________________
☐ Numbness ☐ Tremors ☐ Neck injury ☐ Head injury ☐ Foggy thinking ☐ Poor focus

## Emotions & Mind

☐ Anxiety ☐ Depression ☐ Irritability ☐ Decreased concentration ☐ Panic attacks ☐ Sleep distu rbances ☐ Sadness/tearfulness ☐ Mood swings ☐ Unable to sit still ☐ Easily stressed or confused ☐ Obsessive/compulsive thoughts

## Hormone Axis (Female)

☐Hot flashes ☐ Night sweats ☐ Vaginal dryness ☐ Painful intercourse ☐ Tired constantly ☐ Low libido ☐ Fertility issues ☐ Tender breasts ☐ Premenstrual cramping ☐ Heavy/irregular menses ☐ Frequent yeast infections ☐ Painful menstruation ☐ Postmenopausal ☐ Vaginal discharge
Age of first menstrual cycle: _________
☐ Weight gain in belly ☐ Weight gain in hips ☐ Weight gain despite good diet ☐ Facial puffiness ☐ More tired at rest than with activity ☐ Low blood pressure ☐ Crave salt ☐ Crave sugar

## Hormone Axis (Male)

Please check all that apply to you.
☐Erectile dysfunction ☐ Tired constantly ☐ Swollen testicles ☐ Low libido ☐ Fertility issues ☐ T ender breasts ☐ Gain weight easily

## Sleep

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Snoring ☐ Restless legs ☐ More tired after rest ☐ Waking up tired ☐ Gets tired easily ☐ Light/restless sleep ☐ Problems going back to sleep
Can you get a good night's sleep? ☐ Yes ☐ No
When do you go to bed? __________   When do you wake up? __________

## Hematologic / Lymphatic

☐ Bruising ☐ Bleeding tendencies ☐ Swollen lymph nodes ☐ Reoccurring infections

## Allergic / Immunologic

☐ Eczema ☐ Seasonal allergies

## Specific Health Questions

Please answer and explain as completely as possible.
How much do you drink daily?
Coffee: _________________ Soft drinks: _________________
How many diet drinks do you drink daily?
____________________________________________________
Do you crave or over consume (check all that apply):
☐ Sugar (sweets) ☐ Chocolate ☐ Caffeine ☐ Alcohol
Vegetables per day (#): __________
Chemical / Toxin Exposures (check all that apply):
☐ Cigarette smoke ☐ Pesticides ☐ Mold ☐ Anti-perspirants ☐ Strong chemicals ☐ Strong odors ☐ Lead ☐ PCBs ☐ Mercury

## Lifestyle Overview

Exercise per week: ______________________________ Diet concerns or restrictions: ___________________________________

## Acknowledgment

I certify that the information provided above is accurate and complete to the best of my knowledge.
Patient Signature: ______________________________ Date: _____________