Simms/Mann
UCLA Center for Integrative Oncology
Optimizing Wellness

INTEGRATIVE ASSESSMENT INTAKE FORM

Please fax back to 310-794-9615

First Name:		MI:		Last Name:	
Medical Record Number:		Date of Birth:		Gender:	☐M ☐F
Mailing Address:					
Phone:		Email Address:			

Primary Care Physician:	
Address:	
Telephone:	

Oncologist:	
Address:	
Telephone:	

Who referred you to this program?				
What goal(s) do you have for this visit?				
1)				
2)				
3)				
Are you currently employed?	☐Yes	☐No	☐Self-Employed	☐Retired
What is/was your job?				
What is your relationship status?	☐Single, living alone	☐Married	☐Cohabitating	
☐Divorced	☐Widowed	☐Separated	☐Significant/Partnered Relationship, living separately	

Summary of Current and Past Cancer Treatment *(check all that apply)*

Diagnosis:	When:	Radiation	Chemo	Surgery
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Please list any medications you are currently taking:		
Name:	Dose:	Reason for taking:

Allergic reactions to medications:	
Medication:	Reactions/Intolerance:

Concerns – Rank by Priority *Example: (side effects of chemotherapy)*	Onset *(next week)*	Frequency *(every 3 weeks)*	Severity *(unknown)*
1)			
2)			
3)			
4)			
5)			

Do you use any of the following services?		
(check all that apply)	From whom?	How often?
☐ Chiropractic:		
☐ Massage:		
☐ Naturopathy:		
☐ Physical Therapy:		
☐ Psychological Counseling:		
☐ Traditional Chinese Medicine:		
☐ Other:		

Have you had any prior experience with alternative/complementary care? If yes, please explain:

Please list all serious illnesses you and/or your family have experienced.					
Illness:	Past	Present	Self	Family	Details:
Heart Disease	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Lung Disease (Asthma, etc.)	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	
Digestive	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Breast Cancer	☐	☐	☐	☐	
Colon Cancer	☐	☐	☐	☐	
Prostate Cancer	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

What vitamins/minerals/botanicals or other dietary supplements are you taking now? If you are taking a complicated supplement, such as a multi-vitamin, please include a list of ingredients. *(if you need additional space, copy the label or write in a separate sheet)* **Note: It is important to know all the ingredients to avoid interactions. The label should also note how many pills/tablets constitute a complete dose.**

Brand or other Name (Manufacturer) *Ex: (St. John's Wort/Nature's Way)*	Why taking *(Depressed)*	When started *(2 years ago)*	Dosage/Day *(3 pills/day)*	Ingredients and pills per dose

Nutrition – One Day Diet Recall

Please list all foods and drinks you consumed yesterday. Include meals, snacks, beverages and condiments.

Food Item:	How Prepared (baked, sautéed, etc.)	Amount (cup, tbsp., oz., etc.)
Breakfast		
Snack		
Lunch		
Snack		
Dinner		

Is this a typical day? If not, why not? Please describe:	
How many servings of fruit do you eat/drink each day? (serving = 1 small piece fruit, 1/2 cup juice, 1/2 cup canned, 1/4 cup dried fruit)	

How many servings of vegetables do you consume each day? (serving = 1/2 cup raw or cooked veg, 1 cup fresh veg, 1/4 cup dried, or 1 small piece)				
How many servings of protein do you consume each day? (3 oz. serving = size of a deck of playing cards)				
Your protein comes from what type of source:	☐ Animal	☐ Plant	☐ Both	
How often do you eat sweet foods (fruit snacks or desserts), candy, or snacks?	☐ Daily	☐ More than once/day	☐ Several times/week	☐ Never
How often do you eat salty foods (e.g. pretzels or chips)?	☐ Daily	☐ More than once/day	☐ Several times/week	☐ Never

What type of eater do you consider yourself?						
How would you characterize your diet?	☐ Eat everything	☐ No red meat- Fish/chicken okay	☐ Vegetarian - Milk/eggs okay	☐ Macrobiotic	☐ Vegan	☐ Other
How much water do you drink per day	☐ 6-8 glasses (64 oz.)/day	☐ Other amount:				
How much of other liquids do you drink per day?						

Are there any foods you avoid? If so, what and why?	

Who prepares your meals?		
Who usually shops for food in your home?		
How many people do you usually have dinner with?		
How often do you go out to eat (or order in)?	_____days per week	_____times per month
What has been your weight range during your adult life?	_____ pounds to _____ pounds	
Has your weight changed by more than 10 lbs. in the last 6 months? If yes, please explain:		

Lifestyle Information

Do you drink alcohol?	☐ Yes	☐ No	If yes, what kind?
How much alcohol/beer/wine do you drink daily?			
How much alcohol/beer/wine do you drink monthly?			
If you have stopped, why did you stop?			
Do you use tobacco?	☐ Yes	☐ No	If yes, what kind?
How much tobacco do/did you use each day?			
If you used to but stopped, when did you stop?			
Do you drink caffeinated coffee, soda or tea?	☐ Yes	☐ No	
How much coffee/soda/tea do you drink daily?			

In what physical activities do you currently participate? *(check all that apply)*			
☐ Bicycling	☐ Golf	☐ Pilates	☐ Walk
☐ Dancing	☐ Hiking	☐ Run	☐ Weight or resistance training
☐ Flexibility exercise	☐ Horseback Riding	☐ Swimming	☐ Yoga
☐ Go to gym	☐ House/yard work	☐ Tai Chi/Qi Gong	☐ Other

How often do you exercise aerobically?	How long do you exercise for?
☐ Daily/almost daily	☐ Over 45 minutes per session
☐ 3-5 times a week	☐ 30-45 minutes per session
☐ 1-2 times a week	☐ 20-40 minutes per session
☐ a few times a month	☐ 10-20 minutes per session
☐ Less than once a month	☐ Less than 10 minutes per session

Do you have any barriers to exercising? *(check all that apply)*			
☐ Fatigue	☐ Afraid of falling	☐ Pain/discomfort	☐ Physical impairments
☐ Don't like	☐ No access	☐ Don't know what to do	

What are the major stressors in your life?

What are your methods of coping with stress and do you feel you would benefit from learning new approaches?
What are the things that bring you joy?
What are the things that create the greatest challenges for you?

How would you rate your sleep?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How many hours of sleep do you average per night?				

Please describe your support network:	
Family:	
Friends:	
Other:	

Spiritual History

How religious or spiritually oriented do you consider yourself?			
☐ Strong	☐ Somewhat strong	☐ Not very strong	☐ Not at all

How often do you spend time on religious or spiritual practice?		
☐ Daily	☐ Weekly	☐ Several times a month
☐ Monthly	☐ Several times a year	☐ Once a year or less

Please describe your spiritual/religious practice:

Anything else you would like to share?