Michael Kalsman M.D. PLLC

Integrative Medicine & Medical Acupuncture
3132 NY-417
Olean, NY 14760
716-801-0416

Patient Intake Form

Please take some time to answer the questions on this form. What you write will help me understand all your medical problems and how they are impacting your life and your loved ones. We will review it at your first visit, and the content will guide the recommendations that I will include in your treatment plan.

Name:____ D.O.B ______/______/______

Address:________________________________City:_________________State:____ Zip:_______

Email:____

Preferred phone: ___________________________ Cell Home (circle one)

Secondary phone:__________________________ Cell Home (circle one)

Preferred method of contact: phone email text message (circle one)

What are your goals for this consultation?

____
____
____
____
____

Current Health Concerns (list by priority)	Onset	Frequency	Treatments Used

Other Past Medical History (significant illnesses, hospitalizations, etc)

Problem	When	Comments

Past Surgical History

Procedure	Date	Complications	Painful Scar? (y/n)

Allergies (include medication, food and environmental)

Item	Reaction and Severity

Current Medications (please list OTC, herbals and supplements). You may attach a list.

Medication	Dosage	Date started	Reason

Family History

Relationship	Medical History

LIFESTYLE REVIEW

SLEEP:

How many hours on average do you sleep every night? __________

Do you have problems falling asleep? Yes / No Staying asleep? Yes / No

Do you feel rested upon awakening? Yes / No

Do you dream routinely? Yes / No

EXERCISE:

Activity	Days per week	Time/distance	Intensity

ALCOHOL:

How many alcoholic drinks to you have in a typical week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits) circle one*

None 1-3 4-6 7-10 more than 10

Do you every feel the need to cut down? Yes / No

Do you ever feel guilty about your drinking? Yes / No

If you do not currently drink, do you have a past history of problem drinking? Yes / No

SMOKING:

Do your currently smoke? Yes / No Cigarettes cigars chewing tobacco vaping other

In total how long have (did) you smoked? __________ and on average how much per day over that time? ________ (former smokers please answer)

Have you tried quitting in the past? Yes / No. If so, what is the longest time period?_______

Do you have exposure to second-hand smoke (or have you in the past)? Yes / No

OTHER SUBSTANCE USE:

Do you use other substances such as cannabis, cocaine or other social drugs? Yes / No

If yes, what do you use? ______________________ frequency?_____________________

NUTRITION:

Do you currently follow any special diets or nutritional programs? _______________________

Do you have sensitivities to certain foods? Yes / No
If yes, list food and symptoms: ____

How many times to do you eat out in a given week? _______________

How many servings of fruit do you eat/drink each day? ____________ (Serving = 1 small piece of fruit, 1/2 cup of juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit)

How many servings of vegetables do you eat/drink each day? _________) (Serving = 1/2 cup raw or cooked, 1 cup fresh, green leafy vegetables, 1/4 cup dried or 1 small piece)

How would you describe your relationship with food?
____
____
____
____
____

Please list what you would eat in a typical day:

Breakfast:____
____

Lunch:____
____

Dinner:____
____

Snacks:____
____

Beverages:____
____

How many caffeinated drinks per day?__________ What type? ____________________________

SOCIAL HISTORY

WORK / ENVIRONMENT:
What is your current occupation? ______________________ Past occupation?__________________________

Do you feel there are issues at work that impact your health / well-being? Yes / No If so, what?
____

Do you have any current or past exposures to possible environmental toxins? If so, explain:_______________

____

HOME:
Who do you live with? ____ For how long?______________
Do you have resources for emotional support? Yes ____No____ *(Check all that apply)*
Spouse/Partner ____Family _____Friends ______Religious/Spiritual ______Pets ___Other:_________

Do you have concerns about your current financial or housing situation? Yes / No If so, please explain:
____
____

What hobbies or interests do you enjoy?____

____

What gives your life importance / meaning? ____

____

STRESS:

	Little		Mod		Extreme
How much do you feel stress impacts your daily well-being / health?	1	2	3	4	5

How much stress do the following issues cause you? (Little=1 extreme =5)
______family _____relationships _____work ____finances ____ health _____other

Have you ever been a victim of abuse or significant trauma? Yes / No If yes, please if you are comfortable
____
____

How do you typically deal with your stress? ____

Have you ever tried any of the following? (circle any) Meditation Therapy Yoga/Tai Chi Hypnosis
Biofeedback Breathing exercises Prayer Other:____

Do you have a religious or spiritual practice? Yes / No. If so, what? ___________________________________

OTHER THERAPIES:
What past experiences do you have with alternative and complementary medicine? ______________________
____
____

Last update 4/29/22

WELL-BEING:
Considering ALL aspects of your physical, mental, emotional and spiritual health in the LAST MONTH please rate where you feel your OVERALL well-being is :

0 1 2 3 4 5 6 7 8 9 10
Worst ever Average Best Ever

Considering ALL aspects of your physical, mental, emotional and spiritual health, what do you feel is the most important issue to your well-being?

____

____

____

____