CSUSM
School of Nursing
Student Healthcare Project

INTEGRATIVE HEALTH QUESTIONNAIRE

Integrative Healthcare (IH), as defined by the National Center for Complementary and Alternative Medicine at the National Institutes of Health, "combines mainstream medical therapies and Complementary and Alternative Medicine (CAM) therapies for which there is some high-quality scientific evidence of safety and effectiveness" (IOM, 2009).

Confidential Client Information Supplemental Form

Patient Must Also Complete a Standard Patient Information Sheet and Health History

PERSONAL HEALTH

Name: _____

DOB: _____

Work Stress Level (circle one): High Medium Low

Last visit to a doctor: _____ Reason: _____

Current or past health problems or concerns not listed in the previous form:

Are you under psychiatry care? Yes _____ No _____

If yes, for what reason? _____

What is your doctor's name _____ Phone number _____

Are you currently receiving any other alternative therapies? _____ How often?_____

Do you take any vitamins or herbs? _____ If yes, what, how often and for what?_____

How would you rate your health? 1 being the lowest and 10 the highest _____

Do you have any allergies? _____ If so, what are they to?_____

Do you have high blood pressure? _____ Do you have low blood pressure? _____

Do you use tobacco products? _____ If yes, how much and how often? _____

Do you drink alcohol? _____ If yes, how much and how often? _____

Do you drink caffeinated beverages? _____ If yes, what and how much? _____

What kind of eater are you? (Check all that applies)

_____3 meals daily plus snacks

_____2 meals daily plus snacks

_____on the run

_____stress

_____nervous

_____grazer

_____eat to live

_____for comfort

_____other, describe:

When do you eat?

_____moderately hunger

_____hunger

_____starving

_____when you have to

When do you eat your biggest meal? _____

What types of meals/snacks do you eat? _____

Do you have food craving(s)? _____

What are they for? _____

How much water do you drink daily? _____

Additional Comments:

Do you exercise? _____ If yes, how often and what? _____

How many BM(s) do you have in a week? _____

Do you suffer from headaches? _____

What are your stress factors? _____

Where do you hold your tension? _____

How many hours do you sleep a night? _____

Do you have any tenderness/soreness in your feet at present? _____

If so, where? _____

Female clients only:

Are you pregnant? _____ If yes, when are you due? _____

Do you still have your menstrual periods? _____ How often? _____

How many days? _____ Are they light or heavy? _____

Are they painful? _____

Additional comments:_____

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INTEGRATIVE HEALTH CLIENT POLICY FORM

Integrative Health (IH) Client Policy Form

*** It is always suggested that you talk to your conventional healthcare provider(s) about any integrative healthcare (IH) (to include complimentary alternative therapies, including but not limited to aromatherapy, Ayurveda, Healing Touch, Reiki, that you are receiving or are considering.*

Boundaries:

· Personal and professional boundaries are respected and observed at all times.

· Privacy and confidentiality are maintained at all times.

· Clients are treated with respect and dignity.

Scheduling Policies:

· All IH work sessions will begin and end at scheduled times.

· If a cancellation is necessary by client, please give a 24 hour notice.

· Please do not eat a heavy meal two hours prior to any IH visit or treatment.

After the appointments/treatments:

To receive the maximum benefit of a treatment, it is very important to rest as needed after an IH session. It is suggested that you drink plenty plain water to help flush impurities/toxins after a session. Most clients will experience restful sleep, clearer mind, less stress and a feeling of wellbeing. In some cases, clients may experience an emotional release (crying for example).
_____initial

Disclosure

Guided by Transdisciplinary Models of Evidence-based Integrative Healthcare and The Institutes of Medicine's 2009 position paper "INTEGRATIVE MEDICINE AND PATIENT-CENTERED CARE ",Integrative Healthcare includes individualize plans of care for a variety of clients (i.e., male, female, adult, pediatric) and health-related concerns that consider body, mind, and spirit and related practices (e.g., lifestyle modification, meditation, prayer). It is your responsibility to stay current in your healthcare and report any changes to your integrative healthcare team, which includes your conventional medical care provider(s) and complementary and alternative therapists.

Integrative Healthcare (IH) Treatment Consent and Release Form

I, the undersigned, understand and agree that

1. I as "the Patient" (or Client) and "my Practitioner(s)" are partners in the healing process.
2. Factors that influence my health, wellness, and disease will be taken into consideration, including body, mind, spirit, and community.
3. Appropriate use of both conventional and alternative methods will facilitate my innate healing response.
4. Effective interventions that are natural and less invasive will be used whenever possible.
5. Integrative healthcare is evidence based (based in good science).
6. Ultimately, I will decide how to proceed with my IH treatment(s) based on my values, beliefs, and the available evidence.
7. Alongside treatment, health promotion and the prevention of illness are paramount.

Additionally, by signing below I give my permission to the IH practitioner to:

- Perform the session that s/he deems necessary for my personal requirements. If I am uncomfortable with the treatment at any time, it is my responsibility to inform the practitioner, whereupon treatment shall cease immediately.
- Administer a combination of hands-on and hands-off application during the treatment. I shall let the practitioner know if I am not comfortable being touched or if there are places that I would rather not be touched before session begins.

I understand that:

- Certain IH treatments may put me into very rested and relaxed state of mind. It is my responsibility to make sure that I am fully alert before proceeding to driving.
- If I am a minor (under the age of 18 years) the consent of a parent or guardian is required.
- If I am physically or mentally incapacitated the consent of my legal guardian is required.
- The parent or guardian has the option to attend treatment sessions.

By signing this form, I ,_____ (**print patient name**), give my consent to receive IH that may include Complementary and Alternative Medicine (CAM) therapies to include but not limited to acupressure, aromatherapy, reflexology, Healing Touch, prayer, Reiki, and other integrative therapies as necessary by an integrative healthcare practitioner. **I understand that IH includes conventional medicine and is <u>not a substitute</u> for services that would be provided by my conventional medical care provider**. I understand that it is my responsibility to provide correct and accurate health information to my IH team, which includes my conventional medical providers and CAM therapists. I assume all responsibility for my health should I discontinue IH sessions.

All patients older than 5 years of age must sign below unless incapacitated*.
All signatures are required to be witnessed. If less than 5 years of age or incapacitated, print name and in signature line, indicate "less than 5 years" or "incapacitated"; indicate date.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____

Witness: _____

If patient is less than18 years of age or is somehow incapacitated* an additional signature by parent or legal guardian is required to be witnessed.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name: _____

Date: _____

Witness: _____

*Incapacitated: *An incapacitated person is an individual for whom a guardianship proceeding is initiated. S/he has been determined by court as lacking the capacity to manage or to meet at least some of the essential health and safety requirements.*
An incapacitated person may not be able to make or communicate responsible personal decisions. S/he exhibits an inability to meet his/her own personal needs for medical care, nutrition, clothing, shelter, or safety. If a person cannot make decisions on any of the issues a general guardian will be appointed. If the person has disability only in limited areas, then a limited guardian is sufficient.
A minor may not come under the definition of incapacitated person under certain statutes and is treated separately (USLegal.com (2014).