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LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No ____

If yes, what type? Cigarette ____ Smokeless ____ Cigar ____ Pipe ____ Patch/Gum ____

How much? _____

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

ALCOHOL INTAKE

Have you ever used alcohol? Yes ____ No ____

If yes, how often do you now drink alcohol?

- No longer drink alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ____ No ____

Have you ever had a problem with alcohol? Yes ____ No ____

If yes, indicate time period (month/year) From _____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ____ No ____

If yes, what type(s) and method? (IV, inhaled, smoked, etc) _____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ____ No ____

If yes, indicate which

- Lead
- Arsenic
- Aluminum
- Cadmium
- Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10__ 6-8__ less than 6__

Do you:

Have trouble falling asleep?

Use sleeping aids?

Feel rested upon waking?

Have problems with insomnia?

Snore?

EXERCISE HISTORY

Do you exercise regularly? Yes _____ No _____

If yes, please indicate:

Type of exercise	Times/week				Length of session				min
	1x	2x	3x	4x/+	≤15 min	16-30 min	31-45 min	>45 min	
Jogging/Walking									
Aerobics									
Strength Training									
Pilates/Yoga/Tai Chi									
Sports (tennis, golf, water sports, etc)									
Other (please indicate)									

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes _____ No _____

Do you feel you can easily handle the stress in your life? Yes _____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes _____ No _____

If yes, do you believe that you know the source of your stress? Yes _____ No _____

If yes, what do you believe it to be? _____

Have you ever contemplated suicide? Yes _____ No _____

If yes, how often? _____ When was the last time? _____

Have you ever sought help through counseling? Yes _____ No _____

If yes, what type? (e.g., pastor, psychologist, etc) _____

Did it help? _____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

Spouse Family Friends Religious/Spiritual Pets Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No ___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No ___

Did you feel safe growing up? Yes ___ No ___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No ___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No ___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities:

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes _____ No _____