

Name: _____

Date: _____

Integrative Medicine Survey

Our office has a goal to create an open, inclusive and integrated medical practice in regards to complementary and alternative healing therapies. In order to help us understand what you are currently doing to maintain and improve your health in these areas, please answer the following survey questions.

In the past 5 years have you used any of the following healing practices?

Mind/Body Therapies

- Meditation..... yes no If yes, what is your frequency of practice? _____
- Guided Imagery yes no If yes, what is your frequency of practice? _____
- Art or Music Therapy yes no If yes, what is your frequency of practice? _____
- Hypnosis yes no If yes, what is your frequency of practice? _____
- Biofeedback..... yes no If yes, what is your frequency of practice? _____
- Yoga..... yes no If yes, what is your frequency of practice? _____

Alternative Medicine

- Acupuncture yes no If yes, what is your frequency of practice? _____
- Homeopathy yes no If yes, what is your frequency of practice? _____
- Chiropractic Medicine yes no If yes, what is your frequency of practice? _____
- Ayurveda yes no If yes, what is your frequency of practice? _____
- Chinese Medicine..... yes no If yes, what is your frequency of practice? _____

Manual and Energy Healing

- Massage yes no If yes, what is your frequency of practice? _____
- Reiki yes no If yes, what is your frequency of practice? _____
- Healing Touch..... yes no If yes, what is your frequency of practice? _____
- Reflexology yes no If yes, what is your frequency of practice? _____
- Tai Chi..... yes no If yes, what is your frequency of practice? _____
- Qi Gong yes no If yes, what is your frequency of practice? _____

Environmental Healing

- Aromatherapy..... yes no If yes, what is your frequency of practice? _____
- Electromagnetic Therapy yes no If yes, what is your frequency of practice? _____

Diet and Nutrition

- Antioxidants..... yes no If yes, what is your frequency of practice? _____
- Macrobiotics..... yes no If yes, what is your frequency of practice? _____
- Herbal Supplements yes no If yes, what is your frequency of practice? _____

Please list herbal supplements: (ie. Dong Quai, Black Cohosh, Licorice Root, Chasteberry, Ginkgo, Garlic, Licorice Root, St. John's Wort, Ginger, Feverfew, etc.)

- Vitamin Supplements yes no If yes, what is your frequency of practice? _____
Please list vitamin supplements:

- Soy Products yes no If yes, what is your frequency of practice? _____
Please list soy products used:

Other therapies not listed above:
