Annapolis Integrative Medicine

Comprehensive Intake Questionnaire

This updated questionnaire is designed to efficiently gather the clinical information necessary for evaluating chronic fatigue, fibromyalgia, chronic pain, autonomic dysfunction, hormonal concerns, environmental illness, and complex chronic conditions, using modern diagnostic frameworks and streamlined formatting.

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1. Patient Information

Name: ____
DOB: _ ***Age:***
Marital status: __
Do you have children? If so, how many:
Current employment status: __
What do or did you do for work? ____

Primary reason for today's visit (in your own words):

When did your main symptoms begin?
☐ Sudden onset (approx. date): _____
☐ Gradual onset over time

What do you believe triggered or contributed to your illness?
☐ Infection ☐ Injury ☐ Stress ☐ Chemical exposure ☐ Mold ☐ Vaccine ☐ Surgery ☐ Pregnancy/postpartum ☐ Unknown ☐ Other: _____

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2. Illness Timeline (Recommended)

Please list **major events, treatments, diagnoses, setbacks, improvements**, in order.

Approx. Date	Event / Diagnosis / Symptom Change	Notes (tests, treatments, responses)

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3. Functional Status & Impact

Activity Level (adapted from 2015 IOM ME/CFS criteria)

Compared to before you became ill, what is your typical activity level?

- ☐ 90–100% (normal)
- ☐ 70–89% (mild reduction)
- ☐ 50–69% (moderate reduction)
- ☐ 20–49% (significant reduction)
- ☐ <20% (severely limited/homebound)
- ☐ Bedbound

PROMIS-style impact questions (past 7 days)

Rate 0–10 (0 = none, 10 = worst).

- Fatigue severity: _____
- Pain severity: _____
- Pain interference (daily activities): _____
- Cognitive difficulties ("brain fog"): _____
- Post-exertional malaise: _____
- Poor sleep/unrefreshing sleep: _____

Exercise: - Type of exercise: ___ **- Frequency:** __ ***- If you are no longer able to exercise, what did you used to do?*** __ ***- When did you have to stop?*** ____

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4. Updated Diagnostic Scoring Tools

4A. ME/CFS (2015 Institute of Medicine Criteria)

Check all that apply:

Core symptoms (must have all three):

☐ Substantial impairment in activity lasting >6 months
☐ Post-exertional malaise (PEM)
☐ Non-restorative/unrefreshing sleep

PLUS at least *one* of the following:

☐ Cognitive impairment
☐ Orthostatic intolerance — meaning do you feel light-headed, faint or nearly faint, or your heart races when you go from lying to sitting or standing?

Describe your PEM trigger(s) and recovery time:

4B. Fibromyalgia (2016 ACR Criteria)

Widespread Pain Index (WPI): count painful areas (0–19): _
Symptom Severity Scale (SSS): fatigue + nonrestorative sleep + cognitive + somatic symptoms (0–12): ___

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5. Past Medical History

Check all that apply: ☐ Allergies ☐ Asthma ☐ Autoimmune disease ☐ Thyroid disorder ☐ Adrenal/HPA axis dysfunction ☐ POTS/autonomic disorder ☐ Anxiety ☐ Depression ☐ PTSD ☐ Sleep apnea ☐ IBS ☐ IBD ☐ Gastritis ☐ SIBO ☐ Liver disease ☐ Kidney disease ☐ Diabetes ☐ PCOS ☐ Endometriosis ☐ Chronic infections (Lyme, EBV, etc.) ☐ Mold illness ☐ Chemical sensitivity ☐ Chronic pain ☐ Arthritis ☐ Hypertension ☐ Heart disease ☐ Other: _____

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6. Surgical History

Type of Surgery	Approx. Date	Complications?

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7. Family History

Check relevant conditions in **parents, siblings, grandparents**: ☐ Heart disease ☐ Diabetes ☐ Autoimmune disease ☐ Thyroid disease ☐ Chronic pain ☐ ME/CFS ☐ Fibromyalgia ☐ Depression/anxiety ☐ Dementia ☐ Cancer ☐ Clotting disorders ☐ Other: _____

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8. Medications & Supplements

8A. Current Medications

Medication	Dose	Frequency	Helpful?	Side effects?

Please use the table below to add more details about each medication (e.g., start date, prescriber, notes):

Medication	Dose	Frequency	Start Date	Prescriber	Helpful?	Side effects?	Notes

8B. Supplements / Botanicals

List **all** supplements you currently take:

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9. Lifestyle & Nutrition

Diet type: ☐ Standard American ☐ Gluten-free ☐ Dairy-free ☐ Low FODMAP ☐ Paleo ☐ Vegan/vegetarian ☐ Carnivore ☐ Mediterranean ☐ Other: _____

Typical daily fluid intake: ____ oz water
Caffeine: ☐ None ☐ Mild ☐ Moderate ☐ Heavy

Alcohol: ☐ None ☐ Social ☐ Weekly ☐ Daily
Nicotine/cannabis: _____

Exercise tolerance: ☐ None ☐ Light ☐ Moderate ☐ Heavy—describe: _____

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10. Sleep Assessment

☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Early waking
☐ Nonrestorative sleep ☐ Snoring ☐ Witnessed apneas
☐ Restless legs ☐ Night sweats
Hours per night: _____

Have you ever had a sleep study? If so, when and what was the result? _____

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11. Symptom Review (Modernized)

Check any symptoms present in the past 30 days:

11A. Energy & Autonomic

☐ Fatigue ☐ Post-exertional malaise ☐ Dizziness ☐ Palpitations ☐ Heat intolerance ☐ Cold intolerance ☐ Shakiness ☐ Syncope/fainting ☐ POTS diagnosis

11B. Pain & Musculoskeletal

☐ Widespread pain ☐ Muscle pain ☐ Joint pain ☐ Morning stiffness ☐ TMJ pain ☐ Headaches/migraines

11C. Cognitive & Neurologic

☐ Brain fog ☐ Word-finding difficulty ☐ Memory problems ☐ Sensory overload ☐ Tingling/numbness ☐ Restless legs

11D. Gastrointestinal

☐ Nausea ☐ Reflux ☐ Bloating ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Food intolerances ☐ Suspected SIBO ☐ IBS diagnosis

11E. Hormonal

Thyroid

☐ Weight gain ☐ Hair loss ☐ Cold intolerance ☐ Dry skin ☐ Constipation ☐ Slow thinking

Reproductive hormones

☐ Irregular cycles ☐ PMS/PMDD ☐ Infertility ☐ Low libido ☐ Hot flashes
If female, do you still have periods? If not, when was the last one? _____

HPA axis / stress response

☐ Low morning energy ☐ Afternoon crash ☐ Second wind at night ☐ Feel “tired but wired” ☐ Salt cravings

11F. Immune & Infections

☐ Recurrent sore throat ☐ Swollen nodes ☐ Fevers/chills ☐ Chronic sinus issues ☐ Chronic cough ☐ Frequent infections

11G. Mood

☐ Anxiety ☐ Panic ☐ Depression ☐ Mood swings ☐ Irritability

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12. Environmental & Exposure History

☐ Mold exposure (home/work/school)
☐ Water damage in home

☐ Chemical sensitivity (perfumes, cleaners, etc.)
☐ Heavy metal exposure (occupational/dental)
☐ Pesticide/herbicide exposure
☐ High-stress living environment
☐ History of trauma (violence, sexual, emotional, or verbal)? If so, elaborate as much as you are comfortable doing: ___
☐ **Other exposures:** _____

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13. Previous Testing (check all done previously)

☐ CBC ☐ CMP ☐ Thyroid panel (TSH, free T4, free T3, antibodies)
☐ Cortisol (AM/PM) or salivary cortisol/HPA axis testing
☐ Sex hormones
☐ EBV panel
☐ Lyme & coinfections PCR/serology
☐ Stool PCR/microbiome
☐ SIBO breath test
☐ Mycotoxin testing
☐ ANA/autoimmunity panel
☐ Sleep study ☐ Heart monitoring / tilt table test

Upload or bring copies if available.

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14. Treatment History (Simplified)

Treatments you've tried and response:

Treatment	Tried?	Helpful?	Side Effects?
Physical therapy	☐	☐	☐
Cognitive therapy	☐	☐	☐
Acupuncture	☐	☐	☐
Massage	☐	☐	☐
Chiropractic	☐	☐	☐
Antivirals	☐	☐	☐
Antibiotics	☐	☐	☐
Thyroid meds	☐	☐	☐

Treatment	Tried?	Helpful?	Side Effects?
Low-dose naltrexone	☐	☐	☐
Sleep meds	☐	☐	☐
Hormone therapy	☐	☐	☐
Supplements	☐	☐	☐
Other _____	☐	☐	☐

15. Patient Goals

What are your top **3 goals** for treatment?

1. _____
2. _____
3. _____

Thank you

This form gives us a comprehensive foundation for understanding your health concerns and planning modern, integrative treatment.