INTEGRATIVE MEDICINE FOUNDATION

Get Well Program

Reveal. Restore. Revitalize.

What is the Get Well Program?

The Get Well Program provides integrative medicine therapies to individuals who could not otherwise afford services at Alliance Integrative Medicine. Get Well patients receive four-to-six months of discounted treatments based on their personalized Transformational Wellness Plans — created just for them by one of AIM's Get Well physicians.

Who Can Apply?

- A single mom raising two children and feeling overwhelmed
- A college student suffering from anxiety with no parental support
- A struggling father with low back pain who just lost his job
- A retired senior with arthritis living on a fixed income
- And … YOU or someone you know who meets the following requirements*:

Medical Requirements

- **Currently** have a primary care physician and have had an appointment with them **during the six months prior to your initial consultation** with an AIM physician
- Have a medical condition that is **responsive to alternative therapies**

Financial Requirements

- Meet financial eligibility based on 200% of the current year's federal poverty level guidelines for households or demonstrate extenuating circumstances.
- Provide proof of annual income (recent W2, federal tax return, or two current pay stubs)
- AIM employees, IMF board members, and members of their respective families may NOT apply.

How Do I Apply?

We cannot consider incomplete application packets, so be sure to submit **all** of the following:

- **Completed Get Well Application Form**
- **Completed Clinical Intake form**
- **Completed Medical Symptom Questionnaire**

- **500-word essay** that describes your current health problems and recent medical treatment, as well as an explanation of your critical financial need
- **Proof of annual household income** — recent W2, federal tax return, or two current paystubs
- **Medical records** from the past 12 months

Drop off, mail, or fax your application materials to:

Alliance Integrative Medicine
Attn: Alex Crumley
6400 E. Galbraith Road
Cincinnati, OH 45236
Fax: 513-791-5526

What Happens After I Apply?

- Our Integrative Medicine Foundation committee and/or two AIM physicians will review your application.
- You will receive a final decision by phone and/or mail within four weeks of submitting your application.
- If accepted, a member of AIM's front office staff will contact you to schedule your initial consultation with a physician.

How Much Does the Program Cost?

These costs will be outlined in your welcome letter if you are accepted into the program.

What Healing Treatments Does the Get Well Program Include?

Get Well services may include nutritional counseling, medical acupuncture, chiropractic treatment, applied kinesiology, functional medicine counseling, energy healing, Advanced Allergy Therapeutics, and medical massage.

Laboratory costs are not included in the program.

"The Get Well Program has been a HUGE help to me in the last year. I couldn't have foreseen the challenges I would face and how much I would rely on the treatments and knowledge of my doctor. I love that the Get Well Program makes such incredible resources available to everyone … I am so grateful for the respect, kindness, and wisdom of the doctors, and for my improving health that is a result of all their work!"
—Abby

INTEGRATIVE MEDICINE FOUNDATION

Get Well Program

Application Form

Basic Information

Full Name: Date of Birth:

Address:

Phone Number: (Home) (Mobile)

Email Address:

Financial Information

Total Members in Household: How Many are Currently Employed:

Employer:

Employer Address:

Length of Employment:

Are you currently enrolled with Medicare?

Health Information

Primary Care Physician:

Date of Last Visit:

Please list top three medical conditions:

1.

2.

3.

Are you a current or former patient of Alliance Integrative Medicine?

How did you hear about our program?

For IMF Committee Only

Date Received: Approval Signature #2:

Final Decision: Approval Signature #1:

Alliance
Integrative Medicine

INTAKE FORM

Patient Name: _____ Date of Birth _____ Date: _____

1. Tell us why you are here:
   ☐ For general health and well-being ☐ For a particular concern
   Specify: _____
   _____
2. If you are here for pain, please describe:
   a. Area of pain _____
   b. Length of time you have had this pain _____
   c. Diagnosis received _____
   _____
   _____
   d. Do you recall any specific incident at the time of onset, or prior to onset of pain, that you feel is associated with your condition? _____
   _____
   _____
   e. The pain is: ☐ Constant ☐ Intermittent ☐ Improving ☐ Worsening
   f. Symptoms are worse in the: ☐ morning ☐ afternoon ☐ night ☐ increase or ☐ decrease during the day
   g. The pain interferes with my:
   ☐ Work ☐ Sleep ☐ Daily Routine ☐ Sexual Activity ☐ Recreation ☐ Other _____
   h. Rate the pain on a scale of 1 to 10 (0 = no pain, 10 = worse possible pain) _____
   i. Symptoms are: ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐ Throbbing ☐ Numbness ☐ Tingling
   j. Do your symptoms radiate? _____
   k. Things that aggravate the pain: _____
   l. Things that relieve the pain: _____
3. List health practitioners seen for this condition, treatments received, and effectiveness: _____
   _____
   _____
4. List previous surgeries (including cosmetic surgery): (Attach list if more than 5)
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____
5. Any other hospitalizations, accidents, injuries, broken bones or significant problems:
   _____ Date _____
   _____ Date _____
   _____ Date _____
6. Medical History: (Example: high cholesterol, diabetes, etc. Attach list if more than 4)
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____

7. Drug/Food/Environmental Allergies _____ ☐ Latex Allergy: ☐ / ☐

8. Current medications **and doses**, including over the counter medications:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

9. List all supplements & brand:

1.	5.
2.	6.
3.	7.
4.	8.

10. Diet:

☐ Low Fat ☐ Gluten-Free ☐ Dairy-Free

☐ Regular (eats anything) ☐ Paleo / Ketogenic ☐ Vegetarian / Vegan

☐ Dining Out > 3 meals/week ☐ Other: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snacks & Drinks: _____

Number of bowel movements per day/week:_____

11. Indicate approximate dates and the nature of any traumatic experience you have had. (e.g. death in family, divorce, change of residence, job loss, sexual assault, etc.)

_____ Date _____

_____ Date _____

_____ Date _____

12. Do you suffer from:

☐ Fatigue ☐ Sleep problems ☐ Irritability

☐ Moodiness or depression ☐ Appetite or weight changes ☐ Lack of enjoyment in life

☐ Memory problems ☐ Anxiety

☐ Compulsive behavior (e.g. binge eating, hand washing, checking locked doors, etc.)

13. Do you:

a. Get along with people outside your family	☐ Yes	☐ No
b. Feel isolated or lonely	☐ Yes	☐ No
c. Have clear goals for direction in life	☐ Yes	☐ No
d. Feel satisfied with your life	☐ Yes	☐ No

14. How many days of work have you missed in the past 4 weeks? _____

15. Review of Systems: Please check the box if currently or in the past any of the following symptoms have pertained to you. Do not include brief illnesses (colds, flus) from which you have recovered without complication.

- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Fever
- ☐ Night sweats
- ☐ Excessive fatigue
- ☐ Chills

- ☐ Glasses/contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vision loss
- ☐ Other eye problems

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Pain in ears, sinuses, throat, or teeth
- ☐ Prolonged hoarseness
- ☐ Frequent bloody nose
- ☐ Mouth sores
- ☐ Nasal discharge
- ☐ Snoring
- ☐ Allergic rhinitis

- ☐ Heart attack
- ☐ Chest pain/pressure
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular/fast heartbeat
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Mitral Valve Prolapse
- ☐ Other heart problems
- ☐ Varicose veins
- ☐ High cholesterol
- ☐ Leg pain on walking
- ☐ Pacemaker

- ☐ Immune problems or frequent infections
- ☐ Food Sensitivities:

_____

_____

_____

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma/wheezing
- ☐ Emphysema/chronic bronchitis
- ☐ Tuberculosis exposure

- ☐ Nausea/vomiting
- ☐ Diarrhea or constipation
- ☐ Blood or black tarry stool
- ☐ Change in bowel habits
- ☐ Pain in stomach/abdomen
- ☐ Heartburn/reflux/ulcer
- ☐ Difficulty swallowing
- ☐ Hepatitis/jaundice/liver problems
- ☐ Irritable bowel
- ☐ Other stomach/colon problems
- ☐ Diverticulosis/Diverticulitis
- ☐ Gas or bloating
- ☐ Frequent diarrhea

- ☐ Pain/difficulty with urination
- ☐ Blood in urine
- ☐ Kidney stone
- ☐ Leaking urine
- ☐ Other kidney/urinary problems

- ☐ Diabetes/blood sugar problems
- ☐ Thyroid problems/goiter
- ☐ Excess thirst/hunger/urination
- ☐ Infertility
- ☐ Excess heat/cold intolerance

- ☐ Back or neck pain
- ☐ Joint pain or swelling
- ☐ Morning stiffness < 1/2 hr.
- ☐ Morning stiffness > 1/2 hr.
- ☐ Gout

- ☐ Skin rash or changing mole
- ☐ Breast lump/nipple discharge
- ☐ Skin cancer/precancer
- ☐ Other skin/breast/nail/hair concern or change
- ☐ Rashes that come and go
- ☐ Acne
- ☐ Eczema or psoriasis

- ☐ Seizure
- ☐ Migraine/recurrent headache
- ☐ Concussion
- ☐ Stroke/mini-stroke
- ☐ Sudden loss of ability to see, speak, walk, move
- ☐ Numbness or weakness
- ☐ Passing out
- ☐ Tremor
- ☐ Other neurologic concerns
- ☐ Memory problems
- ☐ Coordination problems

- ☐ Depression, tearfulness
- ☐ Anxiety/panicky feelings
- ☐ Other emotional problems
- ☐ Sleep/concentration problems
- ☐ Any history of mental problems
- ☐ Disordered Eating

- ☐ Previous blood transfusion
- ☐ Abnormal bleeding/bruising
- ☐ Enlarged lymph nodes
- ☐ Anemia/other blood problems
- ☐ Blood clot in leg or lung

Other:

_____

_____

_____

_____

_____

_____

_____

15. Review of Systems:
(continued)

Males Only:

- ☐ Exposure to venereal disease
- ☐ Exposure to AIDS
- ☐ Discharge from the penis
- ☐ Lumps in the testicles
- ☐ Hernia in the groin
- ☐ Prostate problems
- ☐ Sexual difficulties

Females Only:

- ☐ Breast lumps
- ☐ Abnormal mammogram
- ☐ Abnormal menstrual bleeding
- ☐ Premenstrual Syndrome (PMS)
- ☐ Vaginal discharge
- ☐ Abnormal pap smear
- ☐ Abnormal pelvic pain
- ☐ Breast Implants
- ☐ Exposure to venereal disease
- ☐ Exposure to AIDS
- ☐ Sexual difficulties
- ☐ Menopausal
- ☐ Currently Pregnant

Number of pregnancies _____
Number of live births _____
Number of children living _____

16. Life Habits:

	None	Small	Medium	Large
Alcohol	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sugared products	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Fun	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Meditation	☐	☐	☐	☐
Prayer	☐	☐	☐	☐

17. Family History

Please list medical problems. Include diseases such as heart disease, high blood pressure, diabetes, cancer (which type), alcoholism, mental illness, high cholesterol, stroke, kidney disease, liver disease, bleeding disorders, depression, anxiety, chronic pain, arthritis, osteoporosis, or any other significant illness.

(A) denotes alive (D) denotes deceased

Your father's father _____

Your father's mother _____

Your mother's father _____

Your mother's mother _____

Your father _____

Your mother _____

Aunts or Uncles _____

Sibling _____

Sibling _____

Child _____

Child _____

Clear Print

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total 0

EARS

___ Itchy ears Total
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total 0

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression

Total 0

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total 0

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near-or far-sightedness)

Total 0

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total 0

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total 0

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total 0

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total 0

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total 0

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total 0

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total 0

SKIN

___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total 0

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total 0

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total 0

GRAND TOTAL 0

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100