Functional Medicine Information

Name_____ Date_____

Address_____ City_____ State_____

Email address_____ Gender: M F Other

Phone number_____ Date of Birth_____

Marital status: Single Married Divorced Widowed Number of Children___

Employer_____ Work phone number_____

Type of Job/work_____

Spouse Name_____ Phone_____

Emergency contact (if different from spouse)

Name_____Phone_____

Primary Reason for Visit_____

Briefly describe:

_____

_____

_____

Secondary Complaint_____

Briefly describe:

_____

_____

_____

Other Complaints (please list)

_____
_____
_____
_____

List of Medications (if you have a list we can copy it)

_____ _____
_____ _____
_____ _____
_____ _____

List of Supplements

_____
_____
_____
_____

Family History

Mother: Alive___ Deceased___ Health Conditions_____

Father: Alive___ Deceased___ Health Conditions_____

Number of Siblings_____

___Male ___Female Alive___ Dead___ Health Conditions_____

___Male ___Female Alive___ Dead___ Health Conditions_____

___Male ___Female Alive___ Dead___ Health Conditions_____

Tests run on you in the last year (please circle all that apply):

X-rays MRI CT scan Blood work

Other (please list)_____

Do you have access to your results? Yes No

Please list any other physicians you see (including your primary care doctor):

_____
_____
_____

Health Habits

Do you smoke? Yes No How much?_____

Do you drink alcohol? Yes No How much?_____

Do you drink coffee? Yes No How much?_____

How much water do you drink each day?_____

How much soda or juice do you drink each day?_____

How many hours of sleep do you get each night?_____

How many times do you wake up during the night?_____ What time?_____

Please circle any of the following emotions that you feel on a regular basis:

Anger Anxiety Cry easily Depression Fear Feel stuck in life

Frustration Easily agitated Grief Guilt Heartbreak Hopeless

Humiliation Impatient Inadequate Insecure Irritable

Lack of confidence Lack of Joy Lack of courage Low self esteem

Obsessive/Compulsive Overwhelmed Regret Resentment Restless

Sadness Shame Short temper Suicidal tendency Worry

Symptom survey – Please check any symptoms in the appropriate column

Past	Present		Past	Present	
____	____	Abdominal pain/cramps	____	____	Diarrhea
____	____	Acid reflux	____	____	Dizziness
____	____	Acne	____	____	Dry skin
____	____	Allergies	____	____	Eczema
____	____	Anorexia	____	____	Excessive thirst
____	____	Anxiety	____	____	Fatigue
____	____	Arthritis	____	____	Fibromyalgia
____	____	Asthma/bronchitis	____	____	Food allergies
____	____	Bad breath	____	____	Frequent infections
____	____	Behavior/ADHD/Hyperactivity	____	____	Frequent urination
____	____	Belching	____	____	Headaches
____	____	Bloating after eating	____	____	Heartburn
____	____	Blurry vision	____	____	Hemorrhoids
____	____	Body odor	____	____	High blood pressure
____	____	Brain fog	____	____	High cholesterol
____	____	Bruising easily	____	____	Hot flashes
____	____	Canker sores	____	____	Incontinence
____	____	Chronic ear infections	____	____	Infertility
____	____	Chronic pain	____	____	Insomnia
____	____	Chronic stress	____	____	Irritability
____	____	Cold hands and feet	____	____	Kidney stones
____	____	Constipation	____	____	Leg cramps
____	____	Dark circles under eyes	____	____	Low blood pressure
____	____	Depression	____	____	Low blood sugar
____	____	Diabetes	____	____	Low cholesterol

Symptom survey – Please check any symptoms in the appropriate column

Past	Present		Past	Present	
____	____	Lyme disease	____	____	Tendonitis
____	____	Mucus and congestion	____	____	Thyroid condition
____	____	Muscle cramping	____	____	Tinnitus
____	____	Nausea	____	____	Tremors
____	____	Nervousness	____	____	Unexplained hair loss
____	____	Night sweats	____	____	Unexplained weight loss
____	____	Numbness	____	____	Unexplained weight gain
____	____	Osteoporosis/osteopenia	____	____	Urinary tract infections
____	____	Overweight	____	____	Use of birth control
____	____	Pale skin	____	____	Vertigo
____	____	Palpitations	____	____	Vomiting
____	____	Panic attacks	____	____	Wake up at night
____	____	Poor appetite	____	____	Weakness
____	____	Poor memory/memory loss			Females:
____	____	Rectal bleeding	____	____	Irregular cycles
____	____	Rectal/anal itching	____	____	Take birth control
____	____	Seizures	____	____	Painful periods
____	____	Sensitive to cold temps	____	____	Endometriosis
____	____	Sensitive to hot temps	Other:_____		
____	____	Sensitive to cleaning products	_____		
____	____	Sensitive to perfumes/lotions			Males:
____	____	Shortness of breath	____	____	Erectile dysfunction
____	____	Sinus congestion	____	____	Prostate issues
____	____	Skin issues	Other:_____		
____	____	Swelling	_____		

Please initial each line indicating that you have read and agree to each item

____ I understand that functional medicine is a process that takes time in order to make long lasting changes in my body

____ I am dedicated to the process of improving my health

____ I am willing to fully implement the changes recommended by the Doctor

____ I understand that making lifestyle changes is my responsibility and that my results will be reflective of how well I stick to the plan

____ I understand that it is important to communicate with the Doctor in order to get the best results

____ I understand that there are costs involved with functional medicine including the cost of the initial visit ($150), lab testing (varies and may be covered by insurance), supplements (varies), and follow up visits ($69-99)

My Goals for Functional Medicine are:

_____
_____
_____
_____
_____
_____
_____

Signature_____ Date_____