Functional Medicine Intake Form

Name: _____

Gender

◯ Male ◯ Female

DOB: _____ dd / mm / yyyy **Age:** _____

Physical Address: _____ **City:** _____

State: _____ **Zip:** _____

Mailing Address: _____ **Home #:** _____

Work #: _____ **Cell #:** _____

Email Address: _____ **Emergency Contact Name:** _____

Emergency Contact Number: _____ **Medical Insurance Provider:** _____

Primary Care Physician: _____ **Phone Number:** _____

Whom may we thank for your referral?: _____

Comments

MEDICAL HISTORY

Overall how would you rate your health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

How do you rate your energy level?

◯ High ◯ Fairly High ◯ Low ◯ Poor

How do you rate your stress level?

◯ High ◯ Tolerable ◯ Good ◯ Ideal

Do you exercise at least once a week?

◯ Yes ◯ No

How often do you exercise every week?

◯ Once ◯ Twice ◯ Three times or more

What type of exercise do you do?

◯ Aerobic ◯ Anaerobic/Strengthening ◯ Both

Do you have any medical conditions? Please check all that apply

- [ ] Heart Disease
- [ ] High Blood Pressure
- [ ] Ulcers
- [ ] Hormonal Related Issues
- [ ] Blood clotting problems
- [ ] Arthritis or joint problems
- [ ] Epilepsy
- [ ] Immune system disorders
- [ ] High Cholesterol or lipids
- [ ] Cancer
- [ ] Thyroid Disease
- [ ] Lung condition/ Asthma
- [ ] Diabetes
- [ ] Depression
- [ ] Headaches/migraines

Others

Please list and note the year of any surgeries that you have had

Mammography

◯ No ◯ Yes

Mammography Date: _____ dd / mm / yyyy

Mammography Result

◯ Normal ◯ Abnormal

Pap Smear

◯ No ◯ Yes

Pap Smear Date: _____ dd / mm / yyyy

Pap Smear Result

◯ Normal ◯ Abnormal

Bone Density

◯ No ◯ Yes

Bone Density Date: _____ dd / mm / yyyy

Bone Density Result

◯ Normal ◯ Abnormal

MEDICATIONS

Please list all current medication(s): Medication name, Strength, Date Started, How often per day

Please list any Hormones previously taken: Medication name, Date started, Date stopped, Reason

Please check all products that you use occasionally or regularly

- [ ] Pain Reliever
- [ ] Acetaminophen (ex: Tylenol)
- [ ] Neproxen (ex: Aleve)
- [ ] Cough Suppressant (ex: Robitussin DM)
- [ ] Combination product (cough+cold reliever) (ex: Triaminic DM)
- [ ] Antidiarrheals (ex: Imodium, Pepto Bismol, Kaopectate)
- [ ] Antacids (ex: Tagamet, Pepcid, Zantac 75)
- [ ] Aspirin
- [ ] Ibuprofen (ex: Motrin)
- [ ] Ketoprophen (ex: Orudis KT)
- [ ] Antihistamine product (ex: Chlor-Trimetone)
- [ ] Sleep Aids (ex: Excedrin PM, Unisom, Sominex, Nytol)
- [ ] Diet Aids/weight loss products

Others

Vitamins

Minerals

Herbs

Enzymes

Nutrition/protein supplements

Others

Allergies: please check all that apply

- [ ] No known allergies
- [ ] Sulfa drug
- [ ] Aspirin
- [ ] Dye Allergies
- [ ] Pet Allergies
- [ ] Nitrate Allergies
- [ ] Codeine
- [ ] Morphine
- [ ] Food Allergies
- [ ] Penicillin
- [ ] Seasonal Allergies

Others: please list

Please describe the allergic reaction you experienced

FAMILY HISTORY

Mother Age: _____ **Mother Condition:** _____

Father Age: _____ **Father Condition:** _____

Sisters Age: _____ **Sisters Condition:** _____

Brothers Age: _____ **Brothers Condition:** _____

Child/Children Gender 1

○ M ○ F

Child 1 Age: _____ **Child 1 Health:** _____

Child/Children Gender 2

○ M ○ F

Child 2 Age: _____ **Child 2 Health:** _____

Child/Children Gender 3

○ M ○ F

Child 3 Age: _____ **Child 3 Health:** _____

Child/Children Gender 4

○ M ○ F

Child 4 Age: _____ **Child 4 Health:** _____

Skin Conditions

○ No ○ Yes

Skin Conditions Family Member(s): _____

Obesity

○ No ○ Yes

Obesity Family Member(s): _____

Uterine Cancer

○ No ○ Yes

Uterine Cancer Family Member(s): _____

Diabetes

◯ No ◯ Yes

Diabetes Family Member(s): _____

Breast Cancer

◯ No ◯ Yes

Breast Cancer Family Member(s): _____

Heart Disease

◯ No ◯ Yes

Heart Disease Family Member(s): _____

Osteoporosis

◯ No ◯ Yes

Osteoporosis Family Member(s): _____

Depression

◯ No ◯ Yes

Depression Family Member(s): _____

Ovarian Cancer

◯ No ◯ Yes

Ovarian Cancer Family Member(s): _____

Fibrocystic Breast

◯ No ◯ Yes

Fibrocystic Breast Family Member(s): _____

ENERGY LEVEL

How would you rate your energy level on a scale from 1-10? ____/10 (1 means you barely function and 10 means you radiate energy):

Do you feel you should have more energy?

◯ Yes ◯ No

How long have you been feeling this way? _____year(s):

Do you feel constantly tired or fatigued?

◯ Yes ◯ No

Do you wake up tired?

◯ Yes ◯ No

Do you have energy swings?

◯ Yes ◯ No

Are you run down around 4:30pm?

◯ Yes ◯ No

Do you eat something sweet when you feel this way?

◯ Yes ◯ No

Do you feel better at these times after you eat something sweet?

◯ Yes ◯ No

Are you easily exhausted with physical activity?

◯ Yes ◯ No

Do you have difficulty handling stress?

◯ Yes ◯ No

Is it difficult for you to stay up late (after midnight)?

◯ Yes ◯ No

Do you get very tired in the evening or early night?

◯ Yes ◯ No

Do you feel more tired when you are at rest than when active?

◯ Yes ◯ No

Do you have difficulty recovering after staying up late?

◯ Yes ◯ No

Do you feel like you're living in slow motion?

◯ Yes ◯ No

THYROID

Have you ever been diagnosed with a thyroid disorder?

◯ Yes ◯ No

If yes, please note the year of the diagnosis:

Are you Hyperthyroid (high) or Hypothyroid (low)?

◯ High ◯ Low

Do you or have you ever taken thyroid medication?

◯ Yes ◯ No

If yes, for how long?: _____

If yes, what brand and dosage are you currently taking? _____mg _____how often?:

If not at this time, when did you quit taking medication?:

WEIGHT CONTROL

Have you had any significant weight gain?

◯ Yes ◯ No

How many pounds?: _____ **What year did it start?:** _____

Do you feel you put on weight easily?

◯ Yes ◯ No

Do you have difficulty losing weight?

◯ Yes ◯ No

How long have you had this problem? _____year(s):

Do you put on weight around your waist?

◯ Yes ◯ No

Do you put on weight around your thighs and buttocks?

◯ Yes ◯ No

Do you have a flabby abdomen?

◯ Yes ◯ No

Are you pear-shaped?

◯ Yes ◯ No

Is your upper abdomen distended?

◯ Yes ◯ No

Is your lower abdomen distended?

◯ Yes ◯ No

Do you suffer from constipation?

◯ Yes ◯ No

TEMPERATURE SENSITIVITY

Are you sensitive to cold?

◯ Yes ◯ No

Do you hands and feet feel cold?

◯ Yes ◯ No

How long have you experienced this? _____Year(s):

Do you get chills easily?

◯ Yes ◯ No

Do the palms of your hands or feet perspire unusually?

◯ Yes ◯ No

How long have you experienced this? _____Year(s):

Do you have decreased perspiration?

◯ Yes ◯ No

How long have you experienced this? _____Year(s):

MOOD AND MEMORY

Do you ever feel discouraged, blue or depressed?

◯ Yes ◯ No

If yes, what percentage of the time? _____%:

How long have you felt this way?: _____

Do you or have you ever taken antidepressants?

◯ Yes ◯ No

If yes, which ones?

If yes, between what ages?: _____

Are you ever anxious, nervous or irritable?

◯ Yes ◯ No

Do you lose self-control?

◯ Yes ◯ No

Do you have difficulty making decisions or setting goals?

◯ Yes ◯ No

Are you less self-confident now?

◯ Yes ◯ No

If yes, how long have you been this way?:

Do you tend to isolate yourself?

◯ Yes ◯ No

Are you intolerant of noise?

◯ Yes ◯ No

Do small things set you off?

◯ Yes ◯ No

Have you noticed a decrease in mental sharpness?

◯ Yes ◯ No

Do you have poor short term memory?

◯ Yes ◯ No

Do you have trouble concentrating?

◯ Yes ◯ No

SLEEP

How many hours do you sleep each night, on average? _____:

Do you feel you need a lot of sleep?

◯ Yes ◯ No

Do you have trouble falling asleep at night?

◯ Yes ◯ No

Is your mind filled with thoughts as you are trying to go to sleep?

◯ Yes ◯ No

Do you wake up during the night?

◯ Yes ◯ No

Can you go back to sleep easily during the night?

◯ Yes ◯ No

Do you have nervous, anxious or restless sleep?

◯ Yes ◯ No

Do you have a tendency to go to bed late and wake up late?

◯ Yes ◯ No

Do you have difficulty waking up in the morning?

◯ Yes ◯ No

Do you wake up too early with a heavy head in the morning?

◯ Yes ◯ No

When you get up in the morning, are you rested?

◯ Yes ◯ No

Do you take something the help you sleep?

◯ Yes ◯ No

If yes, what do you use? _____: _____

HAIR

Do you have fine hair or coarse hair?

◯ Fine ◯ Coarse

How long have you had this type of hair? _____year(s):

Are you eyebrows or eyelashes thinning?

◯ Yes ◯ No

Do you have hair loss or thinning of hair on your head?

◯ Yes ◯ No

Do you have dry,thick, brittle hair?

◯ Yes ◯ No

Does you hair grow slowly?

◯ Yes ◯ No

Do you have less armpit hair?

◯ Yes ◯ No

Do you have less pubic hair?

◯ Yes ◯ No

Is your hair graying?

◯ Yes ◯ No

Is your hairline receding?

◯ Yes ◯ No

Are you losing your hair on top of your head?

◯ Yes ◯ No

SKIN

Do you have fine lines or crow's feet at the side of your eyes?

◯ Yes ◯ No

Do you have lines on your forehead?

◯ Yes ◯ No

Does the skin on your face look puffy, pale or doughy?

◯ Yes ◯ No

Is the skin on the back of your hands thin?

◯ Yes ◯ No

Do you have lines on the side of your mouth?

◯ Yes ◯ No

Do you have dry skin?

◯ Yes ◯ No

If yes, since when?: _____

Do you have rosacea (redness on the nose and cheeks)?

◯ Yes ◯ No

Do you have eczema, psoriasis or other rashes?

◯ Yes ◯ No

Do you have age spots?

◯ Yes ◯ No

Do you have thin, vertical wrinkles above your lips?

◯ Yes ◯ No

Do your cheeks sag?

◯ Yes ◯ No

Are your nails brittle?

◯ Yes ◯ No

Do you have acne?

◯ Yes ◯ No

EYES

Do you have swelling or puffiness in the morning?

◯ Yes ◯ No

Do you have swollen eyelids in the morning?

◯ Yes ◯ No

Do you have dark circles under your eyes?

◯ Yes ◯ No

How long have you had any of these problems? _____Year(s):

Does the swelling occur often?

◯ Yes ◯ No

Do your eyes feel dry?

◯ Yes ◯ No

Do you see as brightly as before?

◯ Yes ◯ No

Do you wear corrective lenses of any sort?

◯ Yes ◯ No

MUSCULO-SKELETAL

Do you feel your muscles are flabby or slack?

◯ Yes ◯ No

Do your joints get stiff in the morning?

◯ Yes ◯ No

Do you have arthritis?

◯ Yes ◯ No

If yes, where?: _____

Do you have osteoarthritis of the hips?

◯ Yes ◯ No

Do you have muscular pain?

◯ Yes ◯ No

If yes, where?: _____

Do you have bone loss or osteoporosis?

◯ Yes ◯ No

Do you suffer from low back pain?

◯ Yes ◯ No

ADVANCE DIRECTIVES

Do you have an Advanced Directive (Living Will, DNR, Health Care Proxy)?

◯ Yes ◯ No

If yes, please bring in a copy to keep on file in your chart. If no, and you would like to know more and/or wish to develop an Advanced Directive, please speak with the receptionist at the front desk, so that we may provide you with this information.