FUNCTIONAL MEDICINE INITIAL INTAKE FORM

GENERAL INFORMATION

Full Name ______________________________

Date of Birth ____________________ Age ________ Gender ☐ Male ☐ Female

Highest Education Level ☐ High School ☐ Undergraduate ☐ Postgraduate

Job Title ____________________ Nature of Occupation / Business ____________________

CONTACT INFORMATION

Address ______________________________

STREET ADDRESS CITY STATE ZIP

Cell Phone ______________ Home Phone ______________ Work Phone ______________

Email Address ______________________________

Emergency Contact Name ____________________ Emergency Number ______________

Emergency Contact Address ______________________________

STREET ADDRESS CITY STATE ZIP

DOCTOR INFORMATION

Physician's Name ____________________ Phone Number ______________

Who referred you to us?

☐ Google ____

☐ Social Media ___________________________________

☐ Family Member _________________________________

☐ Friend ____

☐ Other ____

FUNCTIONAL MEDICINE QUESTIONNAIRE

ALLERGIES

MEDICATION	REACTION

SUPPLEMENT	REACTION

FOOD	REACTION

COMPLAINTS & CONCERNS

What do you hope to achieve in your visit with us?

____

____

If you had a magic wand and could erase three problems, what would they be?

1. ______________________________
2. ______________________________
3. ______________________________

When was the last time you felt well?

____

Did something trigger your change in health?

____

What makes you feel worse?

____

What makes you feel better?

____

Please list the top three current and ongoing problems in order of priority:

DESCRIBE PROBLEM	MILD	MODERATE	SEVERE
Ex. Headaches		X	

PRIOR TREATMENT / THERAPEUTIC APPROACH	EXCELLENT	GOOD	FAIR
Ex. Elimination Diet	X		

MEDICAL HISTORY – DISEASES / DIAGNOSES / CONDITIONS

Check the box next to the conditions you have and provide date of onset.

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome ____________
- ☐ Inflammatory Bowel Disease ____________
- ☐ Crohn's Disease ____________
- ☐ Ulcerative Colitis ____________
- ☐ Gastritis or Peptic Ulcer Disease ____________
- ☐ GERD (reflux) ____________
- ☐ Celiac Disease ____________
- ☐ Constipation ____________
- ☐ Loose Stools ____________
- ☐ Bloating ____________
- ☐ Flatulence (gas) ____________
- ☐ Other ____________________________

CARDIOVASCULAR

- ☐ Heart Attack ____________
- ☐ Other Heart Disease ____________
- ☐ Stroke ____________
- ☐ Elevated Cholesterol ____________
- ☐ Arrythmia (irregular heart rate) ____________
- ☐ Hypertension (high blood pressure) ____________
- ☐ Rheumatic Fever ____________
- ☐ Mitral Valve Prolapse ____________
- ☐ Other ____________________________

METABOLIC / ENDOCRINE

- ☐ Type 1 Diabetes ______
- ☐ Type 2 Diabetes ______
- ☐ Hypoglycemia ______
- ☐ Insulin Resistance / Pre-Diabetes ______
- ☐ Hypothyroidism (low thyroid) ______
- ☐ Hyperthyroidism (overactive thyroid) ______
- ☐ Polycystic Ovarian Syndrome (PCOS) ______
- ☐ Infertility ______
- ☐ Frequent Weight Fluctuations ______
- ☐ Bulimia ______
- ☐ Anorexia ______
- ☐ Binge Eating Disorder ______
- ☐ Night Eating Syndrome ______
- ☐ Eating Disorder (non-specific) ______
- ☐ Other ______

CANCER

- ☐ Lung Cancer ______
- ☐ Breast Cancer ______
- ☐ Colon Cancer ______
- ☐ Ovarian Cancer ______
- ☐ Prostate Cancer ______
- ☐ Skin Cancer ______
- ☐ Other ______

GENITOURINARY

- ☐ Kidney Stones ______
- ☐ Gout ______
- ☐ Interstitial Cystitis ______
- ☐ Frequent Urinary Tract Infections ______
- ☐ Frequent Yeast Infections ______
- ☐ Erectile and/or Sexual Dysfunction ______
- ☐ Other ______

MUSCULOSKELETAL / PAIN

- ☐ Osteoarthritis ______
- ☐ Fibromyalgia ______
- ☐ Chronic Pain ______
- ☐ Other ______

INFLAMMATORY / IMMUNE

- ☐ Chronic Fatigue Syndrome ______
- ☐ Autoimmune Disease ______
- ☐ Rheumatoid Arthritis ______
- ☐ Lupus SLE ______
- ☐ Immune Deficiency Disease ______
- ☐ Herpes-Genital ______
- ☐ Severe Infection Disease ______
- ☐ Food Allergies ______
- ☐ Poor Immune Function ______
- ☐ Environmental Allergies ______
- ☐ Multiple Chemical Sensitivities ______
- ☐ Latex Allergy ______
- ☐ Other ______

RESPIRATORY DISEASES

- ☐ Asthma ______
- ☐ Chronic Sinusitis ______
- ☐ Bronchitis ______
- ☐ Emphysema ______
- ☐ Pneumonia ______
- ☐ Tuberculosis ______
- ☐ Sleep Apnea ______
- ☐ Other ______

SKIN DISEASES

- ☐ Eczema ______
- ☐ Psoriasis ______
- ☐ Acne ______
- ☐ Melanoma ______
- ☐ Skin Cancer ______
- ☐ Other ______

NEUROLOGIC / MOOD

- ☐ Depression ______
- ☐ Anxiety ______
- ☐ Bipolar Disorder ______
- ☐ Headaches ______
- ☐ Migraines ______
- ☐ ADD/ADHD ______
- ☐ Autism ______
- ☐ Mild Cognitive Impairment ______
- ☐ Memory Problems ______
- ☐ Parkinson's Disease ______
- ☐ Multiple Sclerosis ______
- ☐ ALS ______
- ☐ Seizures ______
- ☐ Other ______

INJURIES

Check box if yes: ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones

SURGERIES

Check box if yes and provide date of surgery:

- ☐ Appendectomy ______
- ☐ Hysterectomy +/– Ovaries ______
- ☐ Gall Bladder ______
- ☐ Hernia ______
- ☐ Tonsillectomy ______
- ☐ Dental Surgery ______
- ☐ Joint Replacement: Knee / Hip ______
- ☐ Spinal Surgery ______
- ☐ Heart Surgery: ______
  Bypass Valve
- ☐ Angioplasty or Stent ______
- ☐ Pacemaker ______
- ☐ Other ______

HOSPITALIZATIONS	
DATE	**REASON**
☐ NONE	

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY

Check box if yes and provide number:

☐ Pregnancies ________ ☐ Baby Over 8 Pounds ________ ☐ Abortion ________

☐ Miscarriage ________ ☐ Living Children ________ ☐ Toxemia

☐ Vaginal Deliveries ________ ☐ Breastfeeding ☐ Postpartum Depression

☐ Caesarean ________ For how long? ____________ ☐ Gestational Diabetes

MENSTRUAL HISTORY

Age at First Period ____________ Menses Frequency ____________ Length ____________

Pain ☐ Yes ☐ No Clotting ☐ Yes ☐ No Has your period ever skipped? ☐ Yes ☐ No

Last Menstrual Period ______________________

Do you use contraception? ☐ Yes ☐ No

Contraception Type: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Hormonal Contraception: ☐ Birth Control ☐ Pills ☐ Patch ☐ Nuva Ring

How long? ____________________

WOMEN'S DISORDERS / HORMONAL IMBALANCES (for women only)

☐ Fibrocystic ☐ Breasts ☐ Endometriosis ☐ Fibroids Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last PAP Test ___________________ ☐ Normal ☐ Abnormal

Are you in menopause? ☐ Yes ☐ No Age at menopause ________

☐ Hot Flashes ☐ Mood Swings ☐ Concentration / Memory Problems ☐ Vaginal Dryness

☐ Decreased Libido ☐ Heavy Bleeding ☐ Joint Pains ☐ Weight Gain ☐ Headaches

☐ Palpitations ☐ Loss of Control of Urine

Use of hormone replacement therapy ☐ Yes ☐ No How long? ____________________

MEN'S HISTORY (for men only)

☐ Prostate Enlargement ☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Prostate Infection ☐ Loss of Control of Urine

☐ Change in Libido ☐ Nocturia (urination at night) How many times a night? ______

☐ Impotence ☐ Urgency / Hesitancy / Change in Urinary Stream

GI HISTORY

Foreign Travel ☐ Yes ☐ No Where? ____________________

Wilderness Camping ☐ Yes ☐ No Where? ____________________

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many? ______ ☐ Tooth Pain

☐ Gold Fillings ☐ Bleeding Gums

☐ Root Canals How many? ______ ☐ Gingivitis

☐ Implants How many? ______ ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (mm/yy)	REASON FOR USE

PREVIOUS MEDICATIONS (Last 5 Years)

MEDICATION	DOSE	FREQUENCY	START DATE (mm/yy)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS (Vitamins / Minerals / Herbs / Homeopathy)

SUPPLEMENT & BRAND	DOSE	FREQUENCY	START DATE (mm/yy)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No

Describe: ______________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blockers (Tagamet, Zantac, Prilosec, etc.)? ☐ Yes ☐ No

Frequent antibiotics? (>2 times / year) ☐ Yes ☐ No

Long-term antibiotics? ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No

Use of oral contraceptives? ☐ Yes ☐ No

NUTRITION HISTORY

Have you ever had a nutritional consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

Describe: ______________________________

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic

☐ No Dairy ☐ No Wheat ☐ No Gluten ☐ Vegetarian ☐ Vegan

Specific Program for Weight Loss / Maintenance Type: ______________________________

Other: ______________________________

Height (feet / inches) ______________ Current Weight ______________

Usual Weight Range (+/- 5 lbs) ______________ Desired Weight Range (+/- 5 lbs) ______________

Highest Adult Weight ______________ Lowest Adult Weight ______________

Weight Fluctuations (>10 lbs) ☐ Yes ☐ No Body Fat % ______________

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid any particular foods? ☐ Yes ☐ No

If yes, types and reason: ____

____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? ______________

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? ______________

How many meals do you eat out per week? ☐ 0–1 ☐ 1–3 ☐ 3–5 ☐ > 5

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Travel frequently
☐ Love to eat
☐ Don’t care to cook
☐ Struggle with eating issues
☐ Eat too much under stress
☐ Eat too little under stress
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Eating in the middle of the night
☐ Non-availability of healthy foods
☐ Confused about nutrition advice
☐ Negative relationship with food
☐ Eat more than 50% of meals away from home
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Significant other or family members don’t like healthy foods
☐ Significant other or family members have special dietary needs or food preferences

SMOKING

Currently Smoking? ☐ Yes ☐ No How many years? __________ Packs per day? __________

Attempts to quit: __________

Previous Smoking? ☐ Yes ☐ No How many years? __________ Packs per day? __________

Second-hand Smoke Exposure? ☐ Yes ☐ No

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz. Wine, 12 oz. Beer, 1.5 oz Spirits*

☐ None (skip to "Other Substances") ☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ > 10

Previous alcohol intake? ☐ None ☐ Yes (☐ Mild ☐ Moderate ☐ High)

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking ☐ Yes ☐ No

episode? Do you get into arguments or physical fights when you have been ☐ Yes ☐ No

drinking? Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake? ☐ Yes ☐ No

Coffee Cups / Day ☐ 1 ☐ 2–4 ☐ > 4 *Tea Cups / Day* ☐ 1 ☐ 2–4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake? ☐ Yes ☐ No

12-oz. Can or Bottle / Day ☐ 1 ☐ 2–4 ☐ > 4

Are you currently using any recreational drugs (marijuana, ecstasy, etc.)? ☐ Yes ☐ No

Type ______________________________

Have you ever used IV recreational drugs? ☐ Yes ☐ No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions per week, and duration)

ACTIVITY	TYPE	FREQUENCY PER WEEK	DURATION IN MINUTES
Stretching			
Cardio / Aerobics			
Strength			
Other			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High

List problems that limit activity: ______________________________

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: ______________________________

PSYCHOSOCIAL

Question	Yes	No
Do you feel significantly less vital than you did a year ago?	☐ Yes	☐ No
Are you happy?	☐ Yes	☐ No
Do you feel your life has meaning and purpose?	☐ Yes	☐ No
Do you believe stress is presently reducing the quality of your life?	☐ Yes	☐ No
Do you like the work you do?	☐ Yes	☐ No
Have you ever experienced major losses in your life?	☐ Yes	☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	☐ Yes	☐ No
Would you describe your experience as a child in your family as happy and secure?	☐ Yes	☐ No

STRESS / COPING

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

Describe: ______________________________

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate on a scale of 1–10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? If yes, how often? __________ ☐ Yes ☐ No

Check all that apply: ☐ Yoga ☐ Meditation ☐ Prayer ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Other: __________

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP / REST

Average number of hours you sleep per night: ☐ > 10 ☐ 8–10 ☐ 6–8 ☐ < 6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

Explain: ____________________

ROLES / RELATIONSHIPS

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Long-term Partnership ☐ Widow

# of Children ________ Age of Each Child ____________________

Who else is living in household? ____________________

Under what circumstances? *(ex: my mother – dementia)* ____________________

____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious / Spiritual

☐ Pets ☐ Other ____________________

HOW WELL HAVE THINGS BEEN GOING FOR YOU?	VERY WELL	FINE	POORLY	DOES NOT APPLY
Overall in your life				
At school				
In your job				
In your social life				
With your friends				
With sex				
With your spouse / significant other				
With your children				
With your parents				
With having a positive attitude				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms: ____________________

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, list all: ____________________

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine, do you feel: ☐ Irritable or Wired ☐ Aches and Pains

Do you adversely react to any of the following?

☐ Monosodium Glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Garlic

☐ Onion ☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other ____________________

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides

☐ Organic Solvents ☐ Heavy Metals ☐ Other ____________________

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., routines, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments ____

____

____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related Activities?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments ____

____

____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments ____

____

____