Functional Medicine Intake

Name:		Date:
Referred by:		
What is your major complaint?		
Other complaints?		
How long has it been since you really felt good?		

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight________ Height___________ Blood Pressure (if known)__________% Body fat___________

How much sleep do you get each night on average?____

Do you have any food allergies, sensitivities or

restrictions?____

Do you smoke, drink alcohol or use recreational drugs?_____________________________________

a. How much, how often?____

b. How often do you drink caffeinated beverages?____

c. How often do you drink diet sodas?____

Please list foods you tend to overeat or crave____

Write briefly about your weight gain/loss history: ____

____

If you weight has fluctuated, then what do you feel triggered your weight fluctuation? (circle)

Heredity Stress Eating Habits Boredom

Was your weight gain/loss (circle):

sudden gradual problem since childhood

List close relatives that have diabetes, heart disease or obesity:_________________________________

____

How is your energy level?____

Are there times in the day that you feel best?____

Are you happy in your life right now?____

What are your main sources of stress?____

Check off any of the following that have applied to you <u>within the last 30 days:</u>

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the U.S.?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

How often do you exercise?____

What is your regimen?____

Circle "Now" or "Past" for only those items with which you identify. ***Ignore anything that does not apply to you.***

Is your life:	**Do you often:**
Now Past ***Satisfactory***	Now Past ***Feel depressed***
Now Past ***Boring***	Now Past ***Have anxiety***
Now Past ***Demanding***	**Do you often:**
Now Past ***Unsatisfactory***	Now Past ***Have irrational fears***
Do you worry over:	Now Past ***Feel upset***
Now Past ***Home life***	Now Past ***Feel things go wrong***
Now Past ***Marriage***	Now Past ***Feel shy***
Now Past ***Children***	Now Past ***Cry***
Now Past ***Job***	Now Past ***Feel inferior***
Now Past ***Income***	**Have you:**
Now Past ***Money problems***	Now Past ***Seriously considered suicide***
Other:	Now Past ***Attempted suicide***

What have you tried doing to resolve your issues that DID NOT work:

____

____

____

Are there any things that you have done that have been helpful regarding these issues?

____

____

Have you become discouraged or stressed about handling this problem?

____

____

What is your motivation for wanting to resolve this/these problems? (What would it allow you to do/feel that you are not currently doing?)

____

____

____

If I asked you what you are really hoping to gain by consulting with me today what would it be?

____

____

____

If we work together in a partnership on improving your health, what could I do in order to be of best service to
you?____

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