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) _____
☐ Other _____

☐ Celiac Disease _____
☐ Constipation _____
☐ Loose Stools _____
☐ Bloating _____
☐ Flatulence (gas) _____

CARDIOVASCULAR

☐ Heart Attack _____
☐ Other Heart Disease _____
☐ Stroke _____
☐ Elevated Cholesterol _____
☐ Arrythmia (irregular heart rate) _____
☐ Other _____

☐ Hypertension (high blood pressure) _____
☐ Rheumatic Fever _____
☐ Mitral Valve Prolapse _____

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 episode? ☐ Yes ☐ No

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

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

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 ☐ Family ☐ 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 _____

_____

_____