

Tell us a little about yourself!

Demographics & Background:

Name: _____ Age: _____ Birthdate: _____

Marital Status: Single Married Divorced Widowed Other: _____

Occupation: _____

Do you have any children? Yes / No If so, how many & what are their ages?

Please briefly list any major diagnoses/health conditions of your immediate family members (parents, siblings).

Why did you seek out functional med clinic?

How did you find us? (i.e., online, friend, doctor referral).

What are your **top 3 goals/issues** that you want addressing through our clinic (what are we focusing on today)?

1. _____

2. _____

3. _____

Other Existing Symptoms or Diagnoses:

1. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

Diet:

Please briefly describe any specific diet restrictions or general diet that you currently follow:

Hydration (what do you drink throughout a day?):

Physical Activity

Describe your activity level: Sedentary Moderate Very Active Other: _____

How frequently do you devote time to exercise?

- I don't exercise with any frequency/regularity 3 times per week or less 5 times per week or more

What type of activities do you utilize? _____

Sleep patterns: How many hours/night of sleep do you typically get? _____

Do you have trouble falling asleep? Yes / No If yes, why (if you know)? _____

Do you have difficulty staying asleep? Yes / No If yes, why (if you know)? _____

Pain issues:

Do you have any pain? Yes / No If so, where? _____

Level of pain? (Please rate on scale of 1-10, 1 being lowest, 10 being the highest) _____

Check if you experience any of the following symptoms:

- | | | |
|---|----------------------------|--------------------------------------|
| _____ Cold intolerance
(getting cold easily) | _____ Hair loss | _____ Fatigue |
| _____ Dry skin | _____ Elevated cholesterol | _____ Weight gain |
| _____ Dry eyes | _____ Constipation | _____ Cold/discolored hands and feet |

Women only:

- | | | |
|------------------------|--------------------------------|-------------------|
| _____ Irregular cycles | _____ Heavy or painful periods | _____ Hot flashes |
| _____ Mood swings | _____ Insomnia | |

List all current medications **and** supplements (please include doses):

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

Create a “timeline” of your health issues, and bring to first visit- Start with childhood until present, list by year or age when health issues occurred. Include all physical and emotional stress or traumas. Make note of when you last felt well. *Note that this can be somewhat general, and we will talk through this during your visit (we will help to fill in gaps, if appropriate).*