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. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
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).*