Functional Medicine Packet

Demographics

Name:	Age:	Sex:	Ethnicity:	Height:
Current weight:	Your ideal Weight	Occupation:	Place of birth:	

Contact Info

Address:	
Phone Number: ( )	Email:
Emergency Contact: Name: Phone Number: ( ) Relation:	

Health Concerns

1. List your **top** health concerns in order of priority (please limit to space here):

Problem	Severity	Treatments Tried	How Successful?
1.			
2.			
3.			
4.			
Others:			

2. When was the last time you felt truly well? _____

3. What do you think are the biggest factor(s) contributing to your health issues?

_____

_____

4. If you could have a magic wand and resolve two issues in your life, what would they be?

I. _____

II. _____

Childhood History

INFANCY: *1*a. Were you a ☐ full term baby ☐ preemie: how early _____ ☐ not sure

b. Were you ☐ bottle fed ☐ breast fed: Until what age? _____ ☐ not sure

c. Were you ☐ vaginally delivered ☐ C-section ☐ not sure

CHILDHOOD: 2. How was your physical health as a child? (*Frequently sick? Any major illnesses [pneumonia, mononucleosis, etc.])*

_____

_____

3. How often did you take antibiotics?

	Less than 3X	3-5 x	More than 5x
As an Infant/Childhood:			
As an Adolescent/Teen:			
As an Adult			

4. Growing up, did you suffer from: (*Check all that apply*) ☐ Asthma ☐ Eczema ☐ Food Allergies

5. a. Did you feel safe growing up? ☐ Yes ☐ No

b. Did you experience any violent or traumatic life experiences or witness any violence or abuse? ☐ Yes ☐ No

c. Was alcoholism or substance abuse present in your childhood home? ☐ Yes ☐ No

Adult History

6. What is your relationship status? ☐ single ☐ partnered ☐ married ☐divorced ☐widowed

7. Who currently lives with you? (*Ex. spouse, children, parents, roommates, etc.*) Please include ages.

_____

_____

8. a. As an adult, have you been involved in abusive relationships? ☐ Yes ☐ No

b . Do you currently feel safe in your home? ☐ Yes ☐ No

c. Do you feel respected and valued in your current relationships? ☐ Yes ☐ No ☐ N/A

Please feel free to elaborate on any responses to this question:

_____

9. Do you have pets? If so, what kind: _____

Any allergies to animals/pet dander? Yes_____ No_____

10. Have you or your family experienced any major life changes recently? Yes_____ No_____

If so, please comment _____

11. a. Do you feel like you have a tribe/community you belong to (ex. gym, sports team, club, church)?

Yes_____ No_____

b) Do you struggle with isolation/loneliness?

Yes_____ No_____

12. a. How important is religion/spirituality in your life?

☐ Not at all	☐ Somewhat important	☐ Very important

b) Religion/Faith you identify with (if applicable) _____

Lifestyle Habits

13. ***SLEEP***:

a) How many hours of sleep do you get a night (on average)? _____

b) Do you feel refreshed when you get up in the morning? ☐ Yes ☐ No

c) Do you have any of the following that affect sleep? (Check all that apply)

☐ Pets/Kids sleeping with you ☐ Restless Legs ☐ Sleep Apnea

☐ Teeth grinding ☐ Snoring Partner ☐ TV in room

14. ***STRESS:***

a) On a scale of 1-10 with 10 being the highest, what is your current stress level? _____

b) What are your biggest stressors? _____

c) How do you manage stress? _____

d) Do you have any hobbies? What? _____

e) Do you have a therapist or mental health professional? _____

f) Are you interested in learning about or doing any of the following for stress? Choose all that apply:

☐ Acupuncture ☐ Deep breathing exercises ☐ Infrared treatments

☐ Fitness coaching ☐ Frequency Specific Microcurrent ☐ Other _____

15. ***DIET:***

I. Childhood/Adolescence

a) How healthy would you say your diet was growing up? _____

b) What percentage of your meals were homecooked? _____% Fast food? _____%

Processed foods _____%

II. Adult

a) Do you drink caffeine (coffee, tea, energy drinks)? ☐ Yes ☐ No

If so, how many cups a day? _____

b) How many sweetened beverages do you have daily (sodas/juices/sports drinks)? _____

c) What types of alcohol do you consume? (*Check all that apply)*

☐ N/A ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Shots

How often do you drink? _____ Number of drinks _____

d) How many glasses (8 fl oz) of water do you typically drink a day? _____

e) Are you currently on any of the following diets? If so, which?

☐ AIP ☐ Diabetic ☐ Keto ☐ Paleo ☐ Vegan ☐ Vegetarian

☐ Whole 30 ☐ Organic ☐ Intermittent fasting ☐ Other_____

f) What type of diet have you felt the best on? _____

g) At any point in your life, have you had any allergies/food sensitivities? ☐ Yes ☐ No

To what? (Please also list reaction) _____

_____

h) Are there foods you strongly dislike? What? _____

i) Do you feel WORSE when you have?

_____high fat foods _____ high protein foods _____high starch foods (bread, pasta, rice)

_____high refined sugars _____alcohol _____gluten _____dairy _____caffeine

j) Do you feel BETTER when you have?

_____high fat foods _____ high protein foods _____high carb foods (bread, pasta, rice)

_____high refined sugars _____alcoholic drinks (1-2 drinks) _____caffeine

k) Does skipping meals affect you (ex. Getting shaky, irritable)? ☐ Yes ☐ No

l) Do you have any teeth/gum issues? Check all that apply.

☐ Metal Fillings/Amalgams ☐ Missing teeth ☐ Dentures ☐ Bridge ☐ Gingivitis

m) In regard to your bowel movements, please circle all that applies in each column below.

FREQUENCY	COLOR	CONSISTENCY
> 3x /day	Yellow, Light Brown	Diarrhea
2-3x/day	Medium Brown consistently	Loose but not watery
1x /day	Very Dark or Black	Soft and well-formed
3-4 x/week	Green Colored	Hard to pass
1x/ week	Blood is Visible	Thin, long, and narrow
	Greasy, Shiny	Small and hard
		Alternating hard/loose
		Floating stools

16. ***PHYSICAL ACTIVITY:***

How many days a week do you intentionally exercise? _____

How long each session? _____

What kind of physical activity do you do? _____

Toxin History

17. a) Do you currently smoke/chew tobacco? ☐ Yes ☐ No ☐ Former smoker

Total years smoked? _____ Number of packs a day? _____

b) Did you have exposure to secondhand smoke growing up? ☐ Yes ☐ No

c) Do you use any THC products like marijuana? If so, what? _____

c) Any recreational drug use (either past/present)_____

18. Have you lived or worked in any water damaged buildings where there may have been exposures to mold?

☐ Yes ☐ No

19. Are you sensitive to or have had an adverse reaction to any of the following?

☐ EMFs ☐ Odors/perfumes ☐ Bright lights ☐ Old (Musty) Buildings

☐ Vaccines ☐ Chemicals – Which ones? _____

20. Have you ever lived in an area with Lyme disease? ☐ Yes ☐ No ☐ Not sure

Have you ever been bit by a tick? ☐ Yes ☐ No ☐ Not sure

21. a) Did/do you drink well water? ☐ Yes ☐ No ☐ Not sure

b) Do you live in a house with leaded paint? ☐ Yes ☐ No ☐ Not sure

c) How many times a week do you eat fish? What kind?_____

22. What kind of occupational chemicals/exposures have you been exposed to?

_____

23. Have you ever had chemo or radiation treatments? ☐ Yes ☐ No

24. How often do you use the following products?

Product	Rarely	Occasionally	Daily	Multiple Times daily
Personal Care products				
Deodorant				
Hair spray/hair gel/mousse				
Make up / foundation / blush / mascara				
Perfume/cologne				
Lipstick/gloss				
Food-Related				
Artificial Sweeteners (ex. Splenda, Sweet& Low)				
Plastic water bottles				
Microwaveable plastic (ex. Tupperware)				
Cleaning Supplies				
Aerosols / Furniture Cleaner				

Medical/Surgical History

25. Please circle any conditions below that you have had in your medical history:

CONDITION	When diagnosed?	Comments
Cardiovascular High blood pressure Heart attack High Cholesterol Stroke (or TIA)		
Musculoskeletal Osteoarthritis Rheumatoid Arthritis Gout		
Psych Anxiety Depression Bipolar ADHD Schizophrenia Other		
Digestive Gallstones GERD (reflux) Crohn's Ulcerative Colitis SIBO Irritable Bowel Syndrome		
Infectious Hepatitis *(A/B/C?)* Herpes Lyme Disease Mold Illness Mono (EBV) Pneumonia		
Respiratory Asthma COPD *(Bronchitis/ emphysema)* Sinusitis Sleep apnea		
Neurological Concussions *(TBIs)* Epilepsy/seizures Neuropathy		
Endocrine Diabetes *(Type I, II or other?)* Thyroid disease (Hashimoto's/ Grave's)		
Immune: Cancer *(what type?)* Chronic Fatigue syndrome/ CFIDS		
Skin Eczema Psoriasis Hives		

Dry Skin		
Other(s):		

PAST SURGERIES	When?	Comments
Removal of Tonsils? Appendix? Gallbladder?		
Hernia repair *(What type?)*		
Hysterectomy *(partial or total?)* Still have ovaries? ***Y / N***		
Oral surgery – root canals implants		
Joint replacement *(Which?)*		
Other(s):		

26. Any other major hospitalizations in the past? For what reason?

_____

_____

OB/GYN History **FOR WOMEN ONLY (questions 27-35):**

27. Age at first period_____

28. Have you had an abnormal Pap Smear? ☐ Yes ☐ No

29. Have you received HPV vaccination(s)? ☐ Yes ☐ No

30. a. Have you had an abnormal Mammogram? ☐ Yes ☐ No

b. Have you had/have breast/uterine cancer? ☐ Yes ☐ No

c. Do you have a Family history of breast/uterine cancer? ☐ Yes ☐ No

31. Have you ever been bothered by taking contraceptives? ☐ Yes ☐ No

32. Have you experienced any of the following?

☐ irritable around your period/ (PMS) ☐ endometriosis ☐ infertility

☐ breast lumps/cysts ☐ ovarian cysts ☐ heavy cycles ☐ irregular cycles

33. Have you ever been pregnant ? Yes_____ No_____

# of term births _____ # of miscarriages _____ # of abortions _____

34. Are you in menopause? No_____ Yes_____ If yes, age at last period_____

35. Check if you are on any of the following:

☐ Estradiol /Estriol ☐ Premarin ☐ Progesterone ☐ Testosterone

☐ DHEA ☐ Wild Yam ☐ Other Hormone replacement _____

b) How long have you been on hormone replacement therapy (if applicable)?_____

Medications/Supplements

Are you allergic to any medications or supplements? (If yes, please list name and reaction)

_____

_____

Current Meds/Supplements *(or attach list):*

Medications:

Name (strength, dose)	Since when?

Supplements:

Name (strength, dose, brand)	Since when?

Symptoms Questionnaire (Mark any symptoms you have experienced in the last 6 months)

General			
	Mild	Mod	Severe
Fatigue			
Hard to fall asleep			
Hard to stay asleep			
- Nightmares			
-No dream recall			
Heat Intolerance			
Cold Intolerance			
Fever			
Eyes			
Eyes tearing			
Bags/dark circles under eyes			
Dry eyes			
Ears			
Low hearing			
Ear noises (ringing)			
Sensitivity to noises			
Nose/Mouth			
Nasal congestion			
Altered Smell			
Post nasal drip			
Sinus pains/pressure			
Snoring			
Sore Throat			
Distorted Taste			
Mouth sores			
Teeth/gum issues			
Cracking at corner of lips			
Difficulty Swallowing			
Dry Mouth			
Hoarseness			
Gastrointestinal			
Abdominal pains-upper			
Abdominal pain-lower			
Bloating			
Blood in Stools			
Burping /Farting			
Constipation			
Diarrhea			
Heartburn			

Hemorrhoids			
	Mild	Mod	Severe
Undigested Food in stools			
Abdominal spasms			
Mucus in Stools			
Nausea/vomiting			
Rectal Itching			
Strong Stool Odor			
Vomiting			
Eating			
Binge Eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Craving CARBS			
Craving SALT			
Poor appetite			
Musculoskeletal			
Cramps in calves			
Join pains			
Join swelling			
Muscle pain			
Muscle stiffness			
Muscle twitches (eyes, or arms/legs)			
Neck tightness			
Tension headaches			
TMJ problems			
Mood/Nerves			
Anxiety /Panic Attacks			
Brain Fog			
Depression			
Difficulty Concentrating			
Dizziness			
Fainting			
Hallucinations			
Irritable			
Numbness /Tingling			
Paranoia			
Seizures			
Suicidal Thoughts			
Tremors			

	Mild	Mod	Severe
Skin			
Acne			
Athlete's Foot			
Bumps on back of upper arms			
Cracking Skin where?_____			
Dry/Flaky Skin			
Easy Bruising			
Eczema			
Herpes-genital			
Hives			
Itchiness Where? _____			
Nail changes			
Brittleness			
Fungus			
Splitting			
Softening			
Thickening			
White spots/lines			
Psoriasis			
Rash Where? _____			
Shingles			
Skin Cancer			
Skin Darkening			
Strong Body Odor			
Thinning Eyebrows			
Thinning Hair			
Vitiligo			
Respiratory			
Bad Breath			
Bad odor in nose			
Cough (dry or wet?)			
Wheezing			

	Mild	Mod	Severe
Cardiovascular			
Chest Pain			
Easily out of breath			
Difficulty lying flat			
High blood pressure			
Irregular pulse			
Palpitations			
Swollen Ankles/feet			
Urinary			
Bed Wetting			
Decreased stream			
Infections (UTIs)			
Pain/burning			
Urgency			
Male Reproductive			
Ejaculation problem			
Erection issue			
Impotence			
Infertility			
Low Libido			
Female Reproductive			
Breast tenderness			
Poor libido			
Hot flashes			
Infertility			
PMS (irritability around periods)			
Spotting			
Vaginal Discharge			
Vaginal Odor			
Vaginal Itch			

Food Log

*Please complete food log for 3 consecutive days with 1 day being a weekend day (unless nutrition packet was filled out recently). *Please record all beverages, including water.

* Do not change your eating unless you have been told to. The purpose of this food record is to analyze your present eating habits, not what it should be.

*Please be as descriptive as possible (ex., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.

*Record the amount of food consumed, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

*Include added items. (Ex: tea with 1 tsp sugar, potato with 2 teaspoons butter, etc.)

	DAY 1	DAY 2	DAY 3
Wake up time?			
BREAKFAST			
Snacks			
LUNCH			
Snacks			
DINNER			
Snacks/ Desserts			
Sleeping time?			