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Functional Medicine / Medical Nutrition

Personalized Health and Wellness Program Intake

[This form is to be completed with the Informed Consent form.]

Name _____ **Date** _____

Date of birth _____ (M/D/Y) **Social Security #** _____ **Sex M F**

Address:_____
_____
_____
_____

E-mailAddress:_____

Telephone number: Home:_____ **Work**:_____
May we leave messages relating to your visits? Y / N

Emergency contact: Name: _____
Phone number:_____ **Relation**:_____

How did you hear about this Clinic? :_____

Please list other health care providers you are seeing:
1. _____
_____
_____
(_____)_____
2. _____
_____
_____
(_____)_____
3. _____
_____
_____
(_____)_____

Please list your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____

If you are female, are you currently pregnant? Yes - No (Please circle one)
Medical history

How would you describe your general state of health (please circle one)?
Excellent – Good - Fair - Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

_____
_____
_____
_____
_____
_____
_____

Do you have any allergies (medicines, environmental, dietary etc.)?

_____
_____
_____
_____

Please list all current medications you are taking (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

Please list past prescription medications and approximate dates.

_____
_____
_____
_____

Approximately how many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (Circle all applicable)
Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections
Alcohol—how often and amount _____
Tobacco—form and amount/day_____
Caffeine—form and amount/day _____
Recreational drugs—form and how often _____
Please indicate what immunizations you have had
☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A
☐ Tetanus booster; date?_____ ☐ "Flu" ☐ Hepatitis B

☐ **MMR (measles, mumps, rubella)** ☐ **Polio** ☐ **Smallpox**
Other _____

Please indicate any adverse reactions in response to any of these vaccines: _____
_____
_____

Do you regularly undergo screening tests? (Physical, pap smear, blood tests, etc.)?
Yes - No? If Yes, Please list:_____
_____
_____

Diet

Do you have any food allergies or intolerances? Please list.
_____
_____
_____
_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?
_____
_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch_____
Dinner_____
Snacks_____
Beverages (type and amount)_____

Family history

Please indicate whether a close relative (parent, child or sibling) has had any of the following:
Allergies_____
Asthma_____
Depression_____
Other mental illness_____
Heart disease_____
Drug abuse/alcoholism_____
High blood pressure_____
Kidney disease_____
Cancer_____
Diabetes_____
Other_____
_____

☐ **I don't know my family medical history**

Environment

Occupation _____
Hobbies_____
Do you exercise regularly? Y / N
What type of exercise do you do?
What is the duration?
How often do you exercise?
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?
Please describe. _____
_____
_____
Please describe the emotional climate of your home: _____
_____
_____
Please approximate the level of daily stress you experience on a scale of 1-10? How well do you believe you handle these stresses? _____
_____
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_____
_____

Notes and Comments:

_____
_____
_____
_____
_____
_____
_____