FOR OFFICE USE ONLY:
Patient Number: _____
D o c t o r : _____
Insurance: _____
Emp. Initials: _____

FUNCTIONAL MEDICINE:
PATIENT INFORMATION:

****Please give your Driver's License and insurance card to the front desk to copy for your records. ****
Patient Name: Last _____ First _____ Date _____ / _____ / _____
Address: _____ City _____ State _____ Zip _____
Cell Phone: (_____) _____ - _____ Home Phone (_____) ____ - _____ Birth date ____ / ____ / ____ Age ____
Sex: ____M ____F Driver's License: _____ Patient Soc. Sec. # _____ - _____ - _____
Marital Status: S M D W Spouse's Name: _____ Referred by: _____
Person responsible for payment: _____ Patient Employed by: _____
Occupation: _____ Work Phone: (____) ____ - _____ Email: _____
Emergency Contact Name / # / Relationship: _____/_____/_____
Primary Care Physician/Facility: _____ Primary Care Phone: _____
Preferred method of contact for appointment reminders (circle one): Phone (home or cell) / text / email

CURRENT HEALTH STATUS/CONCERNS:

Please list current and ongoing health problems:

Problem	Date/Yr of Onset	Severity	Frequency	Treatment Approach	Improvement
Example: Headaches	May 2006	mild/moderate/severe	2 times per week	medication/chiropractic	no/mild/moderate/substantial

What diagnosis(es) or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider(s) (including alternative practitioners) have you seen for these conditions?

_____

How much time have you lost from work or school in the past year due to these conditions? (Days, weeks, months, etc.)

_____

MEDICATIONS

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you **ALLERGIC** to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____
_____

DIAGNOSTIC TESTS/PREVENTATIVE SCREENINGS

DIAGNOSTIC STUDIES	WHEN	LOCATION / RESULTS
Biopsy		
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (*Please indicate type*)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
MRI		
PAP smear (*female only*)		
X-Ray (*Please indicate type*)		
Other (*describe*)		

SURGICAL HISTORY

SURGERIES	WHEN	COMMENTS

REVIEW OF SYSTEMS

Check (√) those items that ***presently*** apply

ALLERGIC/IMMUNOLOGIC
- ❑ Food Allergies/sensitivities
- ❑ Hives
- ❑ Seasonal Allergies/Hay Fever

CARDIOVASCULAR:
- ❑ Ankle swelling
- ❑ Blood clots
- ❑ Breathing heavily/tight chest
- ❑ Chest pain
- ❑ Dizziness upon standing
- ❑ Feeling light-headed when standing
- ❑ Frequent coughs
- ❑ Hands and feet go to sleep/numb/tingling
- ❑ Heart enlargement
- ❑ Heart murmur
- ❑ Heart problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ High Triglycerides
- ❑ Irregular heartbeat
- ❑ Leg pain with walking short distances
- ❑ Low blood pressure
- ❑ Low exercise tolerance
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Poor circulation
- ❑ Rapid heartbeat
- ❑ Sensitive to cold
- ❑ Sensitive to hot
- ❑ Sores that don't heal
- ❑ Varicose veins.

CONSTITUTIONAL/GENERAL
- ❑ Aches/pains
- ❑ Chills
- ❑ Cold hands/feet
- ❑ Daytime sleepiness
- ❑ Difficulty concentrating
- ❑ Difficulty sleeping
- ❑ Difficulty sweating
- ❑ Distorted vision
- ❑ Early waking
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ General weakness
- ❑ Low libido
- ❑ Nervousness
- ❑ Night sweats
- ❑ No dream re-call
- ❑ Sleepwalker

EARS/MOUTH/NOSE/THROAT:
- ❑ Acute smell
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Blisters/Cold sores
- ❑ Canker sores
- ❑ Chronic ear infection
- ❑ Coated tongue
- ❑ Congested/Stuffy
- ❑ Constant clearing of throat
- ❑ Cracked lips/corners
- ❑ Dental problems/toothaches
- ❑ Deviated septum
- ❑ Dysphagia/trouble swallowing
- ❑ Ear discharge
- ❑ Ear itching
- ❑ Ear noises/ringing
- ❑ Ear pain/pressure
- ❑ Enlarged glands in throat
- ❑ Fever blisters
- ❑ Frequent Hoarseness
- ❑ Grind teeth while sleeping
- ❑ Gum disease
- ❑ Hearing aid
- ❑ Hearing loss
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Loss of teeth/dentures
- ❑ Motion sickness
- ❑ Mucus in throat
- ❑ Nasal breathing problems
- ❑ Nasal drip
- ❑ Nasal polyps
- ❑ Nose bleeds
- ❑ Sensitive to loud noises
- ❑ Sinus drainage
- ❑ Sinus pain/pressure
- ❑ Sneezing spells
- ❑ Sores/ulcers (mouth)
- ❑ Sore throat/hoarseness
- ❑ Sore tongue
- ❑ Throat closes up
- ❑ Tubes in ears
- ❑ Tonsilitis
- ❑ Vertigo/Dizziness

- ❑ Symptoms worse in Fall
- ❑ Symptoms worse in Spring
- ❑ Symptoms worse in Summer
- ❑ Symptoms worse in Winter

ENDOCRINE/HORMONES:

- ❑ Changes in hair growth/distribution
- ❑ Feeling drowsy after eating
- ❑ Feeling shaky or faint when hungry
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Type I Diabetes (child)
- ❑ Type II Diabetes (adult)
- ❑ Unexplained weight gain
- ❑ Unexplained weight loss

EYES:

- ❑ Blurred vision
- ❑ Burning in the eyes
- ❑ Cataracts
- ❑ Conjunctivitis
- ❑ Dark circles under eyes
- ❑ Dry or gritty eyes
- ❑ Eye pains
- ❑ Far sightedness
- ❑ Floaters in the eyes
- ❑ Glaucoma
- ❑ Halos around lights
- ❑ Itchy eyes
- ❑ Near sightedness
- ❑ Poor night vision
- ❑ Redness
- ❑ See bright flashes
- ❑ Strong light irritates
- ❑ Swelling
- ❑ Tearing/crusting
- ❑ Visual hallucinations
- ❑ Vision headaches

GASTROINTESTINAL

- ❑ Abdominal gas/bloating
- ❑ Abdominal pain
- ❑ Acid reflux/heartburn
- ❑ Black/tarry stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Discolored stools
- ❑ Excessive appetite
- ❑ Full after eating a small meal
- ❑ Frequent indigestion/belching
- ❑ Gall bladder disease/stones
- ❑ Hemorrhoids
- ❑ Hiatal hernia
- ❑ Loss of appetite
- ❑ Nausea
- ❑ Nervous stomach
- ❑ Rectal bleeding
- ❑ Rectal itching
- ❑ Stomach ulcer
- ❑ Undigested food in stools
- ❑ Use laxatives
- ❑ Vomiting
- ❑ Vomiting blood

GENITOURINARY:

- ❑ A discharge other than urine
- ❑ Bedwetting
- ❑ Bladder control problems
- ❑ Cloudy/foul smelling urine
- ❑ Difficulty starting stream
- ❑ Discolored urine
- ❑ Dribbling
- ❑ Frequent urination
- ❑ Getting up at night to urinate
- ❑ Have Trichomonas
- ❑ Kidney stones
- ❑ Kidney/bladder infections
- ❑ Painful urination/burning
- ❑ Syphilis
- ❑ Urgency

HEAD/NECK:

- ❑ Concussion
- ❑ Face twitch
- ❑ Forgetfulness
- ❑ Hair loss
- ❑ Headache after meals
- ❑ Headache afternoon
- ❑ Headache frontal
- ❑ Headache migraine
- ❑ Headache morning
- ❑ Headache occipital
- ❑ Headache relieved by eating sweets
- ❑ Neck glands swell/lumps in neck

HEMATOLOGIC/LYMPHATIC:

- ❑ Anemia
- ❑ Bleeding/bruising
- ❑ Blood clots
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV/AIDS
- ❑ Jaundice
- ❑ Leukemia

- ❑ Liver problems
- ❑ Lymphoma
- ❑ Myeloma
- ❑ Swollen Glands

INTEGUMENTARY/SKIN:

- ❑ Acne
- ❑ Athlete's foot
- ❑ Boils
- ❑ Bruise easily
- ❑ Bugs love to bite you
- ❑ Bumps on backs of arms and front of thighs
- ❑ Burning on bottoms of feet
- ❑ Calluses
- ❑ Cellulite
- ❑ Changing moles
- ❑ Cuts heal slowly
- ❑ Dandruff
- ❑ Dryness, cracking
- ❑ Eczema
- ❑ Excessive sweating
- ❑ Itching
- ❑ Nail fungus
- ❑ Nails split
- ❑ Oiliness
- ❑ Peeling skin
- ❑ Pigmentation changes
- ❑ Plantar warts
- ❑ Psoriasis
- ❑ Rashes
- ❑ Shingles
- ❑ Skin cancer
- ❑ Skin sensitive to detergents
- ❑ Skin sensitive to fabrics
- ❑ Skin sensitive to lotions/creams
- ❑ Sores
- ❑ Strong body odor
- ❑ White spots/lines on nails

MEN'S HISTORY (*for men only*)

- ❑ Difficulty maintaining erection
- ❑ Difficulty obtaining erection
- ❑ Diminished/low libido
- ❑ Genital pain
- ❑ Inguinal hernia
- ❑ Loss of bladder control
- ❑ Low sperm count/infertility
- ❑ Lumps in testicles
- ❑ Nocturia (urinating at night)
- ❑ Prostate cancer
- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Sores on penis
- ❑ Urgency/hesitancy/change in urine stream

MUSCULOSKELETAL:

- ❑ Arthritis
- ❑ Back injuries
- ❑ Back pain
- ❑ Damp weather bothers you
- ❑ Frequent foot cramps
- ❑ General muscle tension
- ❑ Heel spurs
- ❑ Joint pain
- ❑ Joint stiffness
- ❑ Joint swelling
- ❑ Leg cramps during the day
- ❑ Leg cramps when retiring to bed or at night
- ❑ Muscle cramps
- ❑ Muscle pain
- ❑ Muscle stiffness in mornings
- ❑ Muscle weakness
- ❑ Neck injuries
- ❑ Neck pain
- ❑ Pain between shoulders
- ❑ Pain wakes you up at night
- ❑ Painful feet
- ❑ Rheumatoid arthritis
- ❑ Scoliosis
- ❑ TMJ
- ❑ Weakness in legs and arms

NEUROLOGICAL:

- ❑ Balance problems
- ❑ Confusion
- ❑ Difficulty of speech
- ❑ Double vision
- ❑ Epilepsy/seizures
- ❑ Fainting spells
- ❑ Incoordination
- ❑ Losing consciousness
- ❑ Loss of feeling
- ❑ Memory loss
- ❑ Muscle jerking/twitching/ticks
- ❑ Numbness/tingling
- ❑ Paralysis
- ❑ Pins and needles
- ❑ Stuttering

PSYCHOLOGICAL/EMOTIONAL:

- ❑ Alcoholism
- ❑ Am a workaholic
- ❑ Anxiety
- ❑ Considerable emotional stress
- ❑ Crying often
- ❑ Depression
- ❑ Drug addiction/dependency
- ❑ Eating when nervous

- ❑ Emotional numbness
- ❑ Extreme worry
- ❑ Family history of overusing alcohol
- ❑ Family member had nervous breakdown
- ❑ Feeling angered/irritable
- ❑ Feeling hostile/volatile/aggressive
- ❑ Forgetful
- ❑ Frequently keyed up/jittery
- ❑ Frustration
- ❑ Goes to pieces easily
- ❑ Hallucinations
- ❑ Has had a nervous breakdown
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Hyperactive
- ❑ Indecisiveness
- ❑ Insecurity
- ❑ Listless/groggy
- ❑ Mental sluggishness
- ❑ Misunderstood by others
- ❑ Nail biting
- ❑ Often awakened by frightening dreams
- ❑ Often break out into cold sweats
- ❑ Panic attacks
- ❑ Phobias
- ❑ Previously admitted for psychiatric care
- ❑ Recurrent bad dreams
- ❑ Restless leg syndrome
- ❑ Startled by loud noises
- ❑ Suicidal thoughts
- ❑ Unable to reason
- ❑ Unusual tension
- ❑ Use tranquilizers
- ❑ Withdrawn/feeling lost

RESPIRATORY:

- ❑ Apnea
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic cough
- ❑ Congestion
- ❑ COPD
- ❑ Coughing up blood
- ❑ Croup
- ❑ Difficulty breathing
- ❑ Emphysema
- ❑ Frequent colds
- ❑ Non-productive/dry cough
- ❑ Pneumonia
- ❑ Pain upon inspiration
- ❑ Productive cough
- ❑ Shortness of breath
- ❑ Wheezing

WOMEN'S HISTORY (*for women only*)

- ❑ Breast cancer
- ❑ Breast soreness before period
- ❑ Breast soreness during period
- ❑ Changes in period
- ❑ Decreased libido
- ❑ Endometriosis
- ❑ Fibrocystic/lumpy breasts
- ❑ Fibroid tumors in uterus
- ❑ Heavy periods
- ❑ Hot flashes
- ❑ Infertility
- ❑ Menstrual migraine
- ❑ Mood swings
- ❑ Ovarian cysts
- ❑ Painful periods
- ❑ Partial/total hysterectomy
- ❑ Polycystic ovarian syndrome (PCOS)
- ❑ Pregnant
- ❑ Spotting between periods
- ❑ Vaginal discharge
- ❑ Vaginal dryness

FEMALE MEDICAL HISTORY *(For women only)*

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean _____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion_____
- ❑ Living Children_____
- ❑ Post-partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses? ____ Frequency:_____Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period: ____/____/_____

Do you currently use contraception? Yes___ No___ If yes, what please circle/ ndicate which form:

Condom Diaphragm IUD Partner vasectomy Birth control pills

Patch Nuva Ring Other (please describe) _____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant.

Are you menopausal? Yes___ No____ If yes, age of menopause

Do you currently take hormone replacement? If yes, what type and for how long? _____

PAST MEDICAL HISTORY

IINJURIES/BROKEN BONES	WHEN	COMMENTS

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

ANTIBIOTIC/STEROID USE:

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g., Prednisone, Cortisone, etc.)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

CHILDHOOD HISTORY.

Please answer to the best of your knowledge	Yes	No	Don't Know	Comment
Where you a full-term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment
Cholera				
COVID				
Diphtheria				
Measles				
Mumps				
Pertussis				
Polio (injection)				
Rubella (German Measles)				
Smallpox				
Tetanus				
Typhoid				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc.)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea) _____

CHILDHOOD CONDITIONS

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	Yes	Age
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		
Measles		

	Yes	Age
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g., dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		

As a child did you:

Have a high absence from school? Yes___ No___
Experience chronic exposure to second hand smoke in your home? Yes___ No___
Experience abuse? Yes___ No___
Have alcoholic parents? Yes___ No___

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Breast Cancer									
Celiac disease									
Colon Cancer									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Attack									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis, etc.)									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Ovarian Cancer									
Parkinson's									
Pneumonia/Bronchitis									
Prostate Cancer									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Skin Cancer									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									
Uterine Cancer									

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?		
Ringing in the ears (tinnitus)?		
Have TMJ (temporal mandibular joint) problems?		
Metallic taste in mouth?		
Problems with bad breath (halitosis) or white tongue (thrush)?		
Previously or currently wear braces?		
Problems chewing?		
Floss regularly?		
Do you have amalgam dental fillings? How many?		
Did you receive these fillings as a child?		

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes__No____

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc.)	
Soda with caffeine	
Soda without caffeine	

FOOD DIARY

Place a check mark next to the food/drink that you've consumed in the last week.

Breakfast	Lunch	Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Carnation shake	❑ Brown rice
❑ Butter	❑ Coffee	❑ Butter
❑ Carnation shake	❑ Eat in a cafeteria	❑ Carrots
❑ Cereal	❑ Eat in restaurant	❑ Coffee
❑ Coffee	❑ Fish sandwich	❑ Fish
❑ Donut	❑ Fried foods	❑ Green vegetables
❑ Eggs	❑ Hamburger	❑ Juice
❑ Fruit	❑ Hot dogs	❑ Margarine
❑ Juice	❑ Juice	❑ Milk
❑ Margarine	❑ Leftovers	❑ Pasta
❑ Milk	❑ Lettuce	❑ Potato
❑ Milk protein shake	❑ Margarine	❑ Poultry
❑ Oat bran	❑ Mayo	❑ Red meat
❑ Oat meal	❑ Meat sandwich	❑ Rice
❑ Rice protein	❑ Milk	❑ Salad
❑ Slim fast	❑ Pizza	❑ Salad dressing
❑ Soy protein	❑ Protein shake	❑ Soda
❑ Sugar	❑ Potato chips	❑ Sugar
❑ Sweet roll	❑ Salad	❑ Sweetener
❑ Sweeteners	❑ Salad dressing	❑ Tea
❑ Tea	❑ Slim fast	❑ Vinegar
❑ Toast	❑ Soda	❑ Water
❑ Water	❑ Soup	❑ White rice
❑ Wheat bran	❑ Sugar	❑ Yellow vegetables
❑ Whey protein	❑ Sweetener	❑ Other: (List below)
❑ Yogurt	❑ Tea	
❑ Other: (List below)	❑ Tomato	
	❑ Vegetables	
	❑ Water	
	❑ Yogurt	

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Lacto-Ovo
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Other (describe)_____
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc.?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement?
Yes___ No____
If yes, please name the food or supplement and symptom(s). _____

_____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (Symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes ____ No ____ If yes, what food(s) _____

_____

Do you have an aversion to certain foods? Yes _____No _____

If yes, what food(s) _____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little od

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_____

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Less than weekly
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc.) _____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___ No___

If yes, indicate which

- ❑ Aluminum
- ❑ Arsenic
- ❑ Cadmium
- ❑ Lead
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? More than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids?

STRESS/PSYCHOSOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (Pastor, Psychiatrist, etc.) _____

Did it help?_____

How well have things been going for you with regard to the following:

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Which of the following meditation or relaxation techniques do you practice?

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

If yes, how many times per week total? _____

Hobbies and leisure activities:

_____

_____

OCCUPATIONAL HISTORY

Which chemicals are you exposed to at your occupation? (If none, write none.)_____

List any other additional occupational hazards?_____

Is there anything that you would like to discuss with the medical staff today that you feel you cannot indicate here?

Yes_____ No_____

EXERCISE HISTORY

Do you exercise regularly? Yes___ No____

If yes, please indicate:	**Times/week**				**Length of session**			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Aerobics								
Jogging/running								
Pilates								
Sports (tennis, golf, water sports, etc.)								
Strength Training								
Tai Chi								
Walking								
Yoga								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc.)

_____

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:

Significantly modify your diet	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g., work demands, sleep habits)	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress	5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments _____

_____

_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well-being.

Sincerely,
Your Total Health Systems' Functional Medicine Team

HIPAA Acknowledgement and Consent

I, the undersigned, acknowledge that I have had access to a copy of the **NOTICE OF PRIVACY PRACTICES**. I consent to your disclosure, which you deem necessary in connection with my or my child's condition. This information will only be distributed to your third-party payer for purposes of reimbursement for services provided, and only upon direct request of your third-party payer.

Patient signature_____ **Date**_____

Authorization and Assignment

AUTHORIZATION TO BILL INSURANCE: I understand my insurance will be billed for services rendered at Total Health Systems, PC.

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any moneys due him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT *(if applicable)*: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

ACKNOWLEGMENT AND UNDERSTANDING: I hereby acknowledge;

That if there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or if a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Total Health Systems PC, will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

SPECIAL CONSIDERATION: I understand that should I have a financial hardship and am unable to completely satisfy my deductible/copay/or coinsurance I will notify Total Health Systems, PC and a separate written contract will be created and signed.

Patient signature_____ **Date**_____

Consent to Treat

THIS CONSTITUTES INFORMED CONSENT FOR MEDICAL, PHYSICAL THERAPY, ACUPUNCTURE, AND/OR CHIROPRACTIC

CARE. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Total Health Systems, P.C. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, strains, bleeding, bruising, and infection. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Patient signature_____ **Date**_____

Parent/Legal guardian name (please print)_____

Guardian Signature_____ **Date**_____

TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Total Health Systems, P.C. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

26672 Van Dyke • Centerline • Michigan 48015 • (586) 756-7670
43740 Garfield • Clinton Township • Michigan 48038 • (586) 228-0270
28098 23 Mile Rd • Chesterfield Township • Michigan 48051 • (586) 949-0123
30045 Harper Ave • St Clair Shores • Michigan 48082 • (586) 772-8560
57911 Van Dyke Rd • Washington Township • Michigan 48094 • (586) 781-0800
Fax (586) 228-9019
www.totalhealthsystems.com

TOTAL HEALTH SYSTEMS
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Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed. The information covered by this authorization includes:

X-Rays History Diagnosis Treatment Reports
Other: _____

Persons Authorized to Use or Disclose Information:

Primary Care Physician	PCP Telephone # / Fax
Other Treating Providers	Telephone # / Fax
Family Member, POA, or Guardian	Telephone # / Fax

Please be advised that Total Health Systems is a *Patient Centered Medical Home*. We will coordinate your care and disclose your information with your PCP if authorized.

Expiration Date of Authorization
This authorization is effective through _____unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

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