Feel Good
FUNCTIONAL MEDICINE

Intake Form

2219 Rimland Drive, Suite 301
Bellingham, WA 98226
P.360.739.3611
F.360.255.0437
clinic@feelgoodfunctionalmed.com
www.feelgoodfunctionalmed.com

Intake Form Instructions

Please read these instructions carefully

1. Please give yourself enough time to fill this form as it is a very comprehensive form.

2. Please be sure to complete and return **at least 72 hours (3 business days) prior to your appointment.**

3. Take your time telling your story. The more we know, the better we can help.

4. If you are not sure how to answer, leave a question mark next to the question.

5. Once completed, you may e-mail the filled out form to clinic@feelgoodfunctionalmed.com, fax it to 360-255-0437, or give us a printed copy. Thank you for taking the time to fill out your intake and we look forward to your appointment!

General Information

Date: **Name:**

Name ______________________________
First *Middle* *Last*

Preferred Name ______________________________

Date of Birth ______________________ Place of Birth ______________________

Age ______________________________

Gender Male Female

Primary Address ______________________________
Number, Street *Apt #*
____
City *State/Province* *Zip Code/Postal Code*

Genetic Background
African European Native American Mediterranean
Asian Ashkenazi Middle Eastern Caucasian
Other: ______________________

Highest Education Level High School Under-Graduate Post Graduate

Job Title ______________________ Hours per week ____________

Nature of Business ______________________________

Marital Status Single Married Divorce Widowed
Long Term Partnership

Home Phone ______________________________

Work Phone ______________________________

Cell Phone ______________________________

Email ______________________________

Emergency Contact ______________________________
Name *Phone Number*
____
Number, Street *Apt #*
____
City *State/Province* *Zip Code/Postal Code*

Primary Care Physician ______________________________
Name *Phone Number* *Fax Number*

How did you hear about our office? ______________________________
____

Story Page

Name: Age: Sex: Date:

Please tell us your story about your health.

Medical Questionnaire

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

What do you hope to achieve by working with us? ______________________________

____

If you could permanently eliminate three problems, what would they be?

1. ______________________________
2. ______________________________
3. ______________________________

When was the last time you felt well? ______________________________

____

Did something trigger change in health/symptoms? ______________________________

____

What makes you feel worse? ______________________________

____

What makes you feel better? ______________________________

____

Current Health Status/Concerns

Please provide us with current and ongoing problems

PROBLEM	DATE OF ONSET	SEVERITY/FREQUENCY	TREATMENT APPROACH	SUCCESS
EX. Headaches	*May 2006*	*2 times per week*	*Acupuncture/Aspirin*	*Mild Improvement*

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

What physician or other health care provider (including alternative or complimentary 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?

Medical History

Diseases/Diagnosis/Conditions

Check appropriate box and provide date of onset (mm/yyyy).

Past	Ongoing	GASTROINTESTINAL
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD(reflux)
		Celiac Disease
		Gallstones
		Other

Past	Ongoing	CARDIOVASCULAR
		Heart Attack
		Heart Disease
		Stroke
		Elevated Cholesterol
		Arrhythmia (irregular heartbeat)
		Hypertension (high blood pressure)
		Rheumatic Fever
		Mitral Valve Prolapse
		Other

Past	Ongoing	METABOLIC/ENDOCRINE
		Type I Diabetes
		Type 2 Diabetes
		Hypoglycemia
		Metabolic Syndrome Insulin Resistance or Pre-Diabetes
		Hypothyroidism (low thyroid)
		Hyperthyroidism (overactive thyroid)
		Endocrine Problems
		Polycystic Ovarian Syndrome (PCOS)
		Infertility
		Weight Gain
		Weight Loss
		Frequent Weight Fluctuations
		Bulimia
		Anorexia
		Binge Eating Disorder
		Night Eating Disorder
		Eating Disorder (non-specific)
		Other

Past	Ongoing	CANCER
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Other

Past	Ongoing	GENITAL & URINARY SYSTEMS
		Kidney Stones
		Gout
		Interstitial Cystitis
		Frequent Urinary Tract Infections
		Frequent Yeast Infections
		Erectile Dysfunction or Sexual Dysfunction
		Other

Past	Ongoing	MUSCULOSKELETAL/PAIN
		Osteoarthritis
		Fibromyalgia
		Chronic Pain
		Other

Past	Ongoing	INFLAMMATORY/AUTOIMMUNE
		Chronic Fatigue Syndrome
		Autoimmune Disease
		Rheumatoid Arthritis
		Lupus SLE
		Immune Deficiency Disease
		Herpes-Genital
		Severe Infectious Disease
		Poor Immune Function (frequent infections)
		Food Allergies
		Environmental Allergies
		Multiple Chemical Sensitivities
		Latex Allergy
		Hepatitis
		Other

Medical History *(continued)*

Diseases/Diagnosis/Conditions

Check appropriate box and provide date of onset (mm/yyyy).

Past	Ongoing	RESPIRATORY DISEASE
		Asthma
		Chronic Sinusitis
		Bronchitis
		Emphysema
		Pneumonia
		Tuberculosis
		Sleep Apnea
		Other

Past	Ongoing	SKIN DISEASE
		Eczema
		Psoriasis
		Acne
		Melanoma
		Skin Cancer
		Other

Past	Ongoing	MISCELLANEOUS
		Anemia
		Chicken Pox
		German Measles
		Measles
		Mononucleosis
		Mumps
		Sleep Apnea
		Whooping Cough

Past	Ongoing	NEUROLOGIC/MOOD
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Autism
		Mild Cognitive Impairment
		Memory Problems
		Parkinson’s Disease
		Multiple Sclerosis
		ALS
		Seizures
		Alzheimer's
		Other

Medical History *(continued)*

Check appropriate box and provide date of test/injuries/surgeries (mm/yyyy).

PREVENTIVE TESTS
Full Physical Exam
Bone Density
Colonoscopy
Cardiac Stress Test
EBT Heart Scan
EKG
Hemoccult Test- stool test for blood
MRI
CT Scan
Upper Endoscopy
Upper GI Series
Ultrasound
Mammogram
X-Ray
Other

SURGERIES
Appendectomy
Hysterectomy +/- Ovaries
Gall Bladder
Hernia
Tonsillectomy
Dental Surgery
Joint Replacement (Knee/Hip)
Heart Surgery - ByPass Valve
Angioplasty or Stent
Pacemaker
Other *(List Below)*

INJURIES
Back Injury
Neck Injury
Head Injury
Broken Bones
Other

BLOOD TYPE *(Please Check One)*
A
B
AB
O
Rh+
Unknown

Hospitalizations

NONE

Date	Reason

COMMENTS

Gynecologic History

For Women Only

OBSTETRIC HISTORY *(Check Box If Yes And Provide Number Of)*

Pregnancies	Post Partum Depression
Caesarean	Toxemia
Vaginal Deliveries	Gestational Diabetes
Miscarriage	Baby Over 8 pounds
Abortion	Breast Feeding
Living Children	for how long?

MENSTRUAL HISTORY *(Check Box If Yes)*

Age at First Period?_________ Mensus Frequency?_________ Length?_________ Pain? Yes No

Clotting: Yes No Has your period ever skipped? Yes No For how long?

Last Menstrual Period?____

Use of hormonal contraception such as? Birth Control Pills Patch Nuva Ring

How Long?_________

Do you use contraception? Yes No Condom Diaphragm IUD Partner Vasectomy

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

Do you experience breast tenderness, water retention, irritability or PMS symptoms in the second half of your cycle?

Yes No

Please advise of any other symptoms that you feel are significant:____

Fibrocystic Breasts Endometriosis Fibroids Infertility

Painful Periods Heavy Periods PMS

Last Mammogram?___________________ Breast Biopsy/Date:_______________

Last PAP Test?_______________________ Normal Abnormal

Last Bone Density?___________________ Results: High Low Within Normal Range

Are You In Menopause? Yes No Age at Menopause?___________

Please check off if you are experiencing any of the following symptoms:

Hot Flashes	Mood Swings	Concentration/ Memory Problems	Joint Pains
Vaginal Dryness	Decreased Libido	Heavy Bleeding	Headaches
Weight Gain	Loss of Control of Urine	Palpitations	

Use of hormone replacement therapy? *How Long?*________________

What Type? Estrogen Progesterone Ogen Estrace

Premarin Provera Other: _______________

Men’s History

(For Men Only)

Have you ever had a PSA done? Yes No

PSA Level: 0-2 2-4 4-10 >10

Prostate Enlargement Prostate Infection Change in Libido Impotence

Difficulty Obtaining an Erection Difficulty Maintaining an Erection

Nocturia(urination at night) Yes No How many times a night?______________________

Urgency/Hesitancy/Change in Urinary System Lose of control of Urine

Medications

CURRENT MEDICATIONS				
Medication	Dose	Frequency	Start Date *(month/year)*	Reason For Use

PREVIOUS MEDICATIONS *(LAST 10 YEARS)*				
Medication	Dose	Frequency	Start Date *(month/year)*	Reason For Use

NUTRITIONAL SUPPLEMENTS *(VITAMINS/MINERALS/HERBS/HOMEOPATHY)*				
Supplement & Brand	Dose	Frequency	Start Date *(month/year)*	Reason For Use

Do your medications or supplements ever cause you unusual side effects or problems?	Yes	No
Describe:____		
Have you had prolonged or regular use of NSAIDS (Advil, Aleve,etc.), Motrin, Aspirin?	Yes	No
Have you had prolonged or regular use of Tylenol?	Yes	No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec,etc.)	Yes	No
Frequent antibiotics > 3 times /year	Yes	No
Long term antibiotics	Yes	No
Use of steroids (prednisone, nasal allergy inhalers) in the past	Yes	No
Use of oral contraceptives	Yes	No

Childhood History

Please answer to the best of your knowledge

	Yes	No	Don't Know	Comment
Were you a full term baby?				
A premature birth?				
Vaginal Delivery?				
C-Section?				
Breast fed?				
Bottle fed?				
WHEN PREGNANT WITH YOU, DID YOUR MOTHER:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescriptions 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
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (Injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

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, or other Dairy Products?				
Meat, Vegetables, & Potato Diet				
Vegetarian Diet?				
Diet high in wheat (breads, cereals, pasta)?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes No

If yes, please explain: (EX: milk – diarrhea)____

Childhood Illnesses

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		

	Yes	Age
Mumps		
Pneumonia		
Seasonal Allergies		
Skin Disorders		
Strep Infections		
Tonsillitis		
Upset Stomach, Digestive Problems		
Whooping Cough		
Measles		
Other (describe)		
Other (describe)		
Other (describe)		

As a child did you have a high absence from school? Yes No

If yes, why?____

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.
Please check family members that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Age (if still living)									
Heart Attack									
Age at death (if deceased)									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
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									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Family Health History *(continued)*

Please indicate current and past history to the best of your knowledge.
Please check family members that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

Review Of Symptoms

Past	Ongoing	GENERAL
		Fever
		Chills/Cold all over
		Aches/Pains
		General Weakness
		Difficulty sweating
		Excessive Sweating
		Swollen Glands
		Cold hands & Feet
		Fatigue
		Difficulty falling asleep
		Sleepwalker
		Nightmares
		No dream recall
		Early waking
		Daytime sleepiness
		Distorted vision

Past	Ongoing	EARS
		Aches
		Discharge
		Pains
		Ringing
		Deafness/Hearing loss
		Itching
		Pressure
		Hearing Aid
		Frequent Infections
		Tubes in Ears
		Sensitive to loud noises
		Hearing Hallucinations

Past	Ongoing	HEAD
		Poor Concentration
		Confusion
		Headaches:
		After Meals
		If meals skipped
		Severe
		Migraine
		Frontal
		Occipital
		Afternoon
		Daytime
		Relieved by:
		Eating Sweets
		Concussion/Whiplash
		Mental sluggishness
		Forgetfulness
		Indecisive
		Face twitch
		Poor Memory
		Hair Loss

Past	Ongoing	EYES
		Feeling of sand in eyes
		Double vision
		Blurred vision
		Poor night vision
		See bright flashes
		Halo around lights
		Eye pains
		Dark circles under eyes
		Strong light irritates
		Cataracts
		Floaters in eyes
		Visual hallucinations
		Conjunctivitis

Past	Ongoing	SKIN
		Cuts heal slowly
		Bruise easily
		Rashes
		Pigmentation
		Changing Moles
		Calluses
		Eczema
		Psoriasis
		Dryness/cracking skin
		Oiliness
		Itching
		Acne
		Boils
		Hives
		Fungus on Nails
		Peeling Skin
		Shingles
		Nails Split
		White Spots/Lines on Nails
		Crawling Sensation
		Burning on Bottom of Feet
		Athletes Foot
		Cellulite
		Bugs love to bite you
		Is your skin sensitive to?:
		Sun
		Fabrics
		Detergents
		Lotions/Creams

Past	Ongoing	THROAT
		Mucus
		Difficulty swallowing
		Frequent hoarseness
		Tonsillitis
		Enlarged glands
		Constant clearing of throat
		Throat closes up

Review Of Symptoms *(continued)*

Past	Ongoing	NOSE/SINUSES
		Stuffy
		Bleeding
		Running/Discharge
		Watery nose
		Congested
		Infection
		Polyps
		Acute smell
		Drainage
		Sneezing spells
		Post nasal drip
		No sense of smell
		Do the change of seasons tend to make your symptoms worse? Yes No
		If yes, is it worse in the:
		Spring
		Summer
		Fall
		Winter

Past	Ongoing	CIRCULATION/ RESPIRATION
		Swollen Ankles
		Sensitive to hot
		Sensitive to cold
		Extremities cold or clammy
		Hands/Feet go to sleep/ numbness/tingling
		High Blood Pressure
		Chest Pain
		Pain between shoulders
		Dizziness upon standing
		Fainting Spells
		High cholesterol
		High triglycerides
		Wheezing
		Irregular heartbeat
		Palpitations
		Low exercise tolerance
		Frequent coughs
		Breathing heavily
		Frequently sighing
		Shortness of breath
		Night sweats
		Varicose veins/spider veins
		Mitral valve prolapse
		Murmurs
		Skipped heartbeat
		Heart enlargement
		Angina pain
		Bronchitis/Pneumonia
		Emphysema
		Croup
		Frequent colds
		Heavy/tight chest
		Prior heart attack ?
		When___/___/_____
		Phlebitis

Past	Ongoing	NECK
		Stiffness
		Swelling
		Lumps
		Neck glands swell

		MOUTH
		Coated tongue
		Sore tongue
		Dental problems
		Bleeding gums
		Canker sores
		TMJ
		Cracked lips/ corners
		Chapped lips
		Fever blisters
		Wear dentures
		Grind teeth when sleeping
		Bad breath
		Dry mouth

Review Of Symptoms *(continued)*

Past	Ongoing	GASTROINTESTINAL
		Peptic/Duodenal Ulcer
		Poor appetite
		Excessive appetite
		Gallstones
		Gallbladder pain
		Nervous stomach
		Full feeling after small meal
		Indigestion
		Heartburn
		Acid Reflux
		Hiatal Hernia
		Nausea
		Vomiting
		Vomiting blood
		Abdominal Pains/Cramps
		Gas
		Diarrhea
		Constipation
		Changes in bowels
		Rectal bleeding
		Tarry stools
		Rectal itching
		Use laxatives
		Bloating
		Belch frequently
		Anal itching
		Anal fissures
		Bloody stools
		Undigested food in stools

Past	Ongoing	MEN'S HISTORY *For Men Only*
		Prostate enlargement
		Prostate infection
		Change in libido
		Impotence
		Diminished/poor libido Infertility
		Lumps in testicles
		Sore on penis
		Genital pain
		Hernia
		Prostate cancer
		Low sperm count
		Difficulty obtaining erection
		Difficulty maintaining an erection
		Nocturia (urination at night)
		How many times at night?
		Urgency/Hesitancy/Change in Urinary Stream
		Loss of bladder control

Past	Ongoing	KIDNEY/URINARY TRACT
		Burning
		Frequent urination
		Blood in urine
		Night time urination
		Problem passing urine
		Kidney pain
		Kidney stones
		Painful urination
		Bladder infections
		Kidney infections
		Syphilis
		Bedwetting
		Trichomonas

Past	Ongoing	WOMEN'S HISTORY *For Women Only*
		Fibrocystic breasts
		Lumps in breast
		Fibroid Tumors/Breast
		Spotting
		Heavy periods
		Fibroid Tumors/Uterus
		Painful periods
		Change in period
		Breast soreness before period
		Endometriosis
		Non-period bleeding
		Breast soreness during period
		Vaginal dryness
		Vaginal discharge
		Partial/total hysterectomy
		Hot flashes
		Mood swings
		Concentration/Memory Problems
		Breast cancer
		Ovarian cysts
		Pregnant
		Infertility
		Decreased libido
		Heavy bleeding
		Joint pains
		Headaches
		Weight gain
		Loss of bladder control
		Palpitations

Review Of Symptoms *(continued)*

Past	Ongoing	EMOTIONAL
		Convulsions
		Dizziness
		Fainting Spells
		Blackouts/Amnesia
		Had prior shock therapy
		Frequently keyed up and jittery
		Startled by sudden noises
		Anxiety/Feeling of panic
		Go to pieces easily
		Forgetful
		Listless/groggy
		Withdrawn feeling/Feeling 'lost'
		Had nervous breakdown
		Unable to concentrate/short attention span
		Unable to reason
		Tends to worry needlessly
		Considered a nervous person by others
		Unusual tension
		Frustration
		Emotional numbness
		Often break out in cold sweats
		Profuse sweating
		Depressed
		Often awakened by frightening dreams
		Previously admitted for psychiatric care
		Family member had nervous breakdown
		Use tranquilizers
		Misunderstood by others
		Irritable
		Feeling of hostility/volatile or aggressive
		Fatigue
		Hyperactive
		Restless leg syndrome
		Considered clumsy
		Vision changes

Past	Ongoing	EMOTIONAL *(continued)*
		Unable to coordinate muscles
		Have difficulty falling asleep
		Have difficulty staying asleep
		Daytime sleepiness
		Workaholic
		Have had hallucinations

JOINT/MUSCLES/TENDONS
Pain wakes you
Weakness in legs and arms
Balance problems
Muscle cramping
Head injury
Muscle stiffness in morning
Damp weather bothers you

Feel Good
FUNCTIONAL MEDICINE

CIRS Questionnaire

Chronic Inflammatory Response Syndrome, or CIRS, is a multi-symptom, multi-system illness, resulting from the body's impaired ability to properly clear biotoxins acquired from specific microorganisms. These biotoxins are produced by dinoflagellates, algae, bacteria and molds. Such organisms can be found in water damaged buildings, reef fish, algae blooms, and insect & arthropod vectors, to name a few. Typically, people who have do not have a genetic predisposition to CIRS can recover from exposure to biotoxins. Unfortunately, for many, research has demonstrated that nearly 25% of the population can be potentially impacted by CIRS.

As a multi-symptom, multi-system syndrome, there are many ways in which the body can express the illness. In general, patients with CIRS experience neurological, immune, endocrine and circulatory dysfunction. Symptoms may be so severe that their quality of life is greatly depreciated. Please put a check mark next to the symptom(s) you are experiencing.

- ☐ Fatigue
- ☐ Weakness
- ☐ Aches
- ☐ Muscle Cramps
- ☐ Unusual Pain
- ☐ "Ice Pick" Pain
- ☐ Headaches
- ☐ Light Sensitivity
- ☐ Red Eyes
- ☐ Blurred Vision
- ☐ Tearing
- ☐ Sinus Problems
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Joint Pain
- ☐ Morning Stiffness
- ☐ Memory Issues
- ☐ Focus/Concentration Issues
- ☐ Learning Difficulties
- ☐ Confusion
- ☐ Disorientation
- ☐ Skin Sensitivity
- ☐ Mood Swings
- ☐ Appetite Swings
- ☐ Sweats (night time)
- ☐ Temperature Dysregulation
- ☐ Excessive Thirst
- ☐ Increased Urination
- ☐ Frequent Static Shocks
- ☐ Numbness
- ☐ Tingling
- ☐ Vertigo
- ☐ Metallic Taste
- ☐ Tremors
- ☐ Positive VCS Test
- ☐ Exposure to Mold

Patient Name: ________________________________ Date: _____/______/__________

Pain Assessment

Are you currently in pain? Yes No

Is the source of your pain due to an injury? Yes No

If yes, please describe your injury and the date in which it occurred____

____

If no, please describe how long you have experienced this pain and what you believe it is attributed to

____

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?		
Do you have Gold Fillings?		
Do you have Root Canals?		
Implants?		
Tooth Pain?		
Bleeding Gums?		
Gingivitis?		

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)

Social History

Height (feet/inches)	Current Weight
Usual Weight +/- 5lbs.	Desired Weight Range (+/- 5lbs.)
Highest Adult Weight	Lowest Adult Weight
Weight Fluctuations (>10 lbs.)	Body Fat %

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you grocery shop? Yes No

If no, who does the shopping? ________________________________

Do you avoid any particular foods? Yes No

If yes, types and reason ________________________________

If you could only eat a few foods a week, what would they be?________________________________

____

Do you cook? Yes No

If no, who does the cooking? ________________________________

Do you read food labels? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 >5 *meals per week*

Check all the factors that apply to your current lifestyle and eating habits

Erratic eating pattern	Love to eat
Fast eater	Eat because I have to
Late night eating	Have a negative relationship with food
Dislike healthy food	Struggle with eating issues
Significant other or family members don't like healthy foods	Emotional eater (eat when sad, lonely, depressed, bored)
Eat more than 50% meals away from home	Eat too much under stress
Travel frequently	Eat too little under stress
Non-availability of healthy foods	Don't care to cook
Do not plan meals or menus	Eating in the middle of the night
Reliance on convenience	Confused about nutrition advice
Poor snack choices	Significant other or family members have special dietary needs or food preferences
Time constraints	Eat too much

The most important thing I should change about my diet to improve my health is:

____

Nutritional History

Have you made any changes in your eating habits because of your health? Yes No

Food Diary

Place a check mark next to the food/drink that applies to your current diet.

USUAL BREAKFAST
None
Bacon/Sausage
Bagel
Butter
Cereal
Coffee
Donut
Eggs
Fruit
Juice
Margarine
Milk
Oat bran
Sugar
Sweet roll
Sweetener
Tea
Toast
Water
Wheat bran
Yogurt
Oatmeal
Milk protein shake
Slim fast
Carnation shake
Soy protein
Whey protein
Rice protein
Other: (List below)

USUAL LUNCH
None
Butter
Coffee
Eat in a cafeteria
Eat in restaurant
Fish sandwich
Fried foods
Hamburger
Hot dogs
Juice
Leftovers
Lettuce
Margarine
Mayo
Meat sandwich
Milk
Pizza
Potato chips
Salad
Salad dressing
Soda
Soup
Sugar
Sweetener
Tea
Tomato
Vegetables
Water
Yogurt
Slim fast
Carnation shake
Protein shake
Other: (List below)

USUAL DINNER
None
Beans (legumes)
Brown rice
Butter
Carrots
Coffee
Fish
Green vegetables
Juice
Margarine
Milk
Pasta
Potato
Poultry
Red meat
Rice
Salad
Salad dressing
Soda
Sugar
Sweetener
Tea
Vinegar
Water
White rice
Yellow vegetables
Other: (List below)

Nutritional History *(continued)*

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	
Diet Soda	
Ice Cream	
Salty foods	
Slices of white bread (rolls,bagels,etc)	
Soda with caffeine	
Soda without caffeine	
Cups of tea containing caffeine	

Do you currently follow a special diet or nutritional program? Yes No

Gluten-Free Diabetic Dairy Restricted Vegetarian Vegan Blood type diet

Other:____

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:	DO YOU FEEL BETTER WHEN YOU EAT A LOT OF:
High fat foods	High fat foods
High protein foods	High protein foods
High carbohydrate foods (breads, pasta, potatoes)	High carbohydrate foods (breads, pasta, potatoes)
Refined sugar (junk food)	Refined sugar (junk food)
Fried foods	Fried foods
1 or 2 alcoholic drinks	1 or 2 alcoholic drinks
Other:	Other:

Nutritional History *(continued)*

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) ______________________________

____

How many times do you chew your food? ______________________________

How much fluid do you drink with your meals?______________________________

How many servings of fruits & vegetables do you eat per week?______________________________

What foods do you dislike? ______________________________

What foods do you not tolerate well or do you react to? ______________________________

What type of cuisine do you like? ______________________________

What is your typical breakfast? ______________________________

How much time do you have in the morning to prepare breakfast? ______________________________

What is your typical lunch? ______________________________

What is your typical dinner? ______________________________

What meats do you eat? ______________________________

Do you eat eggs? ______________________________

Do you ever do vegetarian? If so how often? ______________________________

What foods do you crave? ______________________________

Do you have snacks during the day? If so what do you snack on? ______________________________

Do you eat fish or other seafood? If so what types? ______________________________

Do you eat dessert? If so what do you eat? ______________________________

Do you skip any meals? ______________________________

What time do you eat your breakfast, lunch, dinner? ______________________________

What time do you usually eat snacks? ______________________________

What types of beverages do you consume? ______________________________

How many ounces/mls of water do you consume daily? ______________________________

What oils do you cook with? ______________________________

Caffeine Intake: Yes No

Coffee Cups/day: 1 2-4 > per day

Tea Cups/day: 1 2-4 > per day

Caffeinated Sodas or Diet Sodas Intake: Yes No

12-ounce can/bottle: 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): ______________________________

Digestive History

Foreign Travel? Yes No Where?

Wilderness Camping? Yes No Where?

Have you ever had severe? Gastroenteritis Diarrhea

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

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

FREQUENCY	
More than 3x a day	
1-3x a day	
4-6x a week	
2-3x a week	
1 or fewer x a week	

CONSISTENCY	
Soft and well formed	
Often floats	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

COLOR	
Medium brown consistently	
Very dark or black	
Greenish color	
Blood is visible	
Varies a lot	
Dark brown consistently	
Yellow, light brown	
Greasy, shiny appearance	

INTESTINAL GAS:	
	Daily
	Occasionally
	Excessive
	Present with Pain
	Foul Smelling
	Little Odor

Lifestyle History

Smoking

Currently Smoking: Yes No How many years?___________ Packs per day?___________
Attempts to quit:_______________
Previous Smoking: How many years?___________ Packs per day?___________
Second Hand Smoke?___________

Alcohol Intake

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

None 1-3 4-6 7-10 >10 *If "None," skip to Other Substances*

Previous alcohol intake? Yes (Mild Moderate High) None

Have you been told you should cut down your alcohol intake?	Yes	No
Do you get annoyed when people ask you about your drinking?	Yes	No
Do you feel guilty about your alcohol consumption?	Yes	No
Do you ever take an eye opener?	Yes	No
Do you notice a tolerance to alcohol (can you hold more than others)?	Yes	No
Have you ever been unable to remember what you did during a drinking episode?	Yes	No
Do you get into arguments or physical fights when you have been drinking alcohol?	Yes	No
Have you ever been arrested or hospitalized because of drinking?	Yes	No
Have you ever thought about getting help to control or stop your drinking?	Yes	No

Other Substances

Are you currently using any recreational drugs? Yes No Type:____________________________

Have you ever used IV or inhaled recreational drugs? Yes No Type:__________________________

Exercise

Do you exercise regularly? Yes No

Current exercise program; (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency per week	Duration in Minutes
Stretching/Jogging/Walking			
Cardio/Aerobics			
Strength Training			
Other(Yoga, Pilates, Gyrotonics,etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading,etc.)			
Other			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity:____

____

Do you feel unusually fatigued after exercise? Yes No

If yes please describe:____

____

Do you usually sweat when exercising? Yes No

Psychosocial

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you still believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

Stress/Coping

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

Do you feel you have an excessive amount of stress in your life? Yes No

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

Daily Stressors: Rate on scale 1-10. (1 - minimal stress. 10 - very high stress)

Work______ Family_____ Social______ Finances______ Health_______ Other_______

Do you practice meditation or relaxation technique? Yes No

Check all that apply

Yoga Meditation Imagery Breathing Tai Chi Prayer Other __________

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

Hobbies & Leisure activities: ____

Sleep and Rest

Average number of hours you sleep per night >10 8-10 6-8 <6

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No

What time do you go to bed? _______________

What time do you wake up? ________________

Roles/Relationships

List Children

CHILD'S NAME	AGE	GENDER

Who is living in your household? Number:___________ Names:_______________________________________

Their Employment/Occupations:____

Resources for emotional support? ____

Check all thay apply:

Spouse Family Friends Religious/Spiritual Pets Other:

Are you satisfied with your sex life? Yes No

HOW WELL HAVE THINGS BEEN GOING FOR YOU?	*Very Well*	*Fine*	*Poorly*	*Does Not Apply*
Overall				
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				

Disc Scoring Sheet

In order to determine your Communication Style, please complete the following:

For each of the 10 word groups below, select the word that is MOST like you, LEAST like you, and IN BETWEEN. You are to assign 4 points to the word that is most like you, 3 points to the word that is like you, 2 points to the word that is somewhat like you, and 1 point to the word that is least like you. (There should be a 4, a 3, a 2, and a 1 on each line. See the example). Once you have completed this, follow the next set of instructions.

Example:

1.	3	Determined	4	Convincing	1	Predictable	2	Cautious

1.		Determined		Convincing		Predictable		Cautious
2.		Strong Willed		Persuasive		Easy-going		Orderly
3.		Direct		Expressive		Kind		Analytical
4.		Bold		Sociable		Cooperative		Precise
5.		Outspoken		Animated		Patient		Logical
6.		Decisive		Talkative		Loyal		Controlled
7.		Daring		Outgoing		Agreeable		Careful
8.		Restless		Enthusiastic		Considerate		Thorough
9.		Competitive		Inspiring		Consistent		Detailed
10.		Aggressive		Playful		Satisfied		Accurate

Once you have assigned numbers to all 10 word groups, total the points for each column and write the total in the spaces provided below.

Totals:				
Styles:	D	I	S	C

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Toxin Exposure Questionnaire

Patient Name________________________________ Date__________

Please check the best response for each of the following questions. Your provider will discuss your answers with you.

FOOD & WATER	YES	SOMETIMES	IN THE PAST	NO
1. Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?	☐	☐	☐	☐
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)	☐	☐	☐	☐
3. Do you consume canned or farmed fish and seafood?	☐	☐	☐	☐
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	☐	☐	☐	☐
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐	☐	☐
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)?	☐	☐	☐	☐

HOME & WORK ENVIRONMENT	YES	SOMETIMES	IN THE PAST	NO
1. Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV?	☐	☐	☐	☐
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐	☐	☐
3. Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)?	☐	☐	☐	☐
4. Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work?	☐	☐	☐	☐
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐	☐	☐
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	☐	☐	☐	☐
7. Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)?	☐	☐	☐	☐
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	☐	☐	☐	☐
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	☐	☐	☐	☐
10. Do you live or work in a sealed building with recirculated air?	☐	☐	☐	☐

© 2017 The Institute for Functional Medicine

TRAVEL & RECREATION	YES	SOMETIMES	IN THE PAST	NO
1. Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?	☐	☐	☐	☐
2. Do you travel by air?	☐	☐	☐	☐
3. Do you run or bike to work along busy streets?	☐	☐	☐	☐
4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?	☐	☐	☐	☐
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	☐	☐	☐	☐

MEDICAL & PERSONAL CARE	YES	SOMETIMES	IN THE PAST	NO
1. Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps?	☐	☐	☐	☐
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	☐	☐	☐	☐
3. Do you smoke, or are you often exposed to second-hand smoke?	☐	☐	☐	☐
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	☐	☐	☐	☐
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	☐	☐	☐	☐
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐	☐	☐
7. Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies?	☐	☐	☐	☐
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	☐	☐	☐	☐
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	☐	☐	☐	☐

Note: For more information on the questions included here, please see the **Toxin Exposure Questionnaire—Bibliography** in IFM's Clinical Practice Toolkit.

IFM®

© 2017 The Institute for Functional Medicine

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

Comments:

Thank you for taking the time to complete this health history 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,

The Clinic Staff at Feel Good Functional Medicine