Functional Medicine Intake Form

Date: _____ SSN_____

Birthdate: _____ Sex: ☐M ☐F Age: _____

Last Name: _____ First Name: _____
Middle Int.: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

☐Married ☐Single ☐Widowed ☐Minor ☐Separated ☐Divorced ☐Student ☐Child

Email: _____

Spouse's Name: _____ Birthdate: _____

* **IN CASE OF EMERGENCY, CONTACT:**

Name: _____ Relationship: _____

Home/Cell Phone: _____ Work Phone: _____

To whom may we THANK for referring you to our office? _____

Have you consulted with a chiropractor before: ☐Yes ☐No If so, Whom:
_____

Occupation: _____ Employer: _____ How long: _____

Employer Phone: _____ May we contact you at work: ☐Yes ☐No

Employer Address: _____

Primary Insurance: _____ Policy Number:
_____

Name of insured: _____ Group Number:
_____

Insured's Birthdate: _____ Relationship to Insured: _____

Insured's Employer: _____ Employer Address:
_____

Secondary Insurance: _____ Policy Number: _____

Name of insured: _____ Group Number: _____

Insured's Birthdate: _____ Relationship to Insured: _____

Insured's Employer: _____ Employer Address: _____

Health Concerns/Goals:

What are your main health goals and concerns that you brought you in today?

_____

_____

_____

_____

How long have you been experiencing this? _____

Describe any factors that may have perpetrated or contributed to your condition:

_____

_____

_____

Have you consulted with any other doctors/professionals for this condition? If yes, please describe? _____

_____

_____

Would you like improvement with any of the following?

- ☐ Digestion: reflux, gas, constipation
- ☐ Weight: loss, management, gain
- ☐ Energy levels, fatigue, brain fog
- ☐ Other: _____
- ☐ Skin: rashes, eczema, acne
- ☐ Sleep: falling asleep, staying asleep
- ☐ Hormones: fertility, PMS, sex drive

Medical History

Please list any hospitalizations, surgeries and injuries you have experienced: _____

_____

_____

Please list any known allergies or food sensitivities: _____

_____

Please list ALL medications and supplements taken on regular basis: _____

_____

_____

Family History:

☐ Alcoholism	☐ Asthma	☐ Alzheimer's	☐ Cancer
☐ Depression	☐ Diabetes	☐ Drug Abuse	☐ Eczema
☐ Epilepsy	☐ Fibromyalgia	☐ Heart Disease	☐ High Cholesterol
☐ High Blood Pressure	☐ Kidney Disease	☐ Mental Illness	☐ Multiple Sclerosis
☐ Osteoporosis	☐ Osteoarthritis	☐ Psoriasis	☐ Thyroid Disorders

Others not listed: _____

_____

Wellness:

Do you feel you have energy throughout the day? (Circle one) Yes No

How often do you exercise? _____

What type of exercise? _____

Overall Stress Level? (Circle one) None Minimal Moderate Severe

Emotions you have been feeling a little more than usual in the past month? (Please check all that apply)

☐ Angry	☐ Anxious	☐ Annoyed	☐ Frustrated	☐ Fearful
☐ Hopeless	☐ Helpless	☐ Easily irritated	☐ Depressed	☐ Panic
☐ Grief	☐ Guilt	☐ Overworked	☐ Overwhelmed	☐ Outraged
☐ Restless	☐ Sad	☐ Worried	☐ Other:	

Please describe any pain and/or tension in your body: _____

_____

_____

_____

For Women:

Age of 1st period? _____ Number of pregnancies? _____ Number of children? _____

Is your menstrual regular? Yes or No Average days of cycle? _____

How many days does your period last? _____ Is the flow? Heavy Light Normal

Which pre-menstrual symptoms do you experience?

☐ Breast Distention	☐ Breast Tenderness	☐ Anxiety
☐ Irritability	☐ Food Cravings	☐ Water Retention
☐ Headaches/Migraines	☐ Anxiety	☐ Nausea
☐ Depression	☐ Vomiting	☐ Diarrhea
☐ Constipation	☐ Cramps	☐ Other: _____

Describe your cramps. Is it stabbing, aching, better with or without movement, low back or abdominal, better with heat or ice, etc.? _____

_____

_____

Do you have vaginal discharge? Yes or No If yes, describe it. _____

_____

Are you currently in peri-menopause or menopause? Yes or No If yes, please describe your symptoms. _____

_____

_____

For Men:

Do you experience any of the following:

- ☐ Swollen testes
- ☐ Impotence
- ☐ Feeling of cold/numbness in external genitalia
- ☐ Testicular pain
- ☐ Pre-mature ejaculation
- ☐ Erectile dysfunction
- ☐ Other: _____

Diet & Digestion:

How many meals do you eat a day? _____

Do you eat:

- ☐ Dairy
- ☐ Meat
- ☐ Vegetables
- ☐ Fruit
- ☐ Candy/ Sweets

Do you crave:

- ☐ Sweet
- ☐ Salty
- ☐ Bitter
- ☐ Spicy
- ☐ Chocolate
- ☐ Other: _____

Do you avoid any foods? Yes or No If yes, please list _____

_____

How much do you drink per day?

- ☐ Water _____
- ☐ Soda _____
- ☐ Alcohol _____
- ☐ Coffee _____

Do you smoke? Yes or No If yes, how many per day? _____

Do you ever have indigestion after eating or stomach pain? Yes or No If yes, please describe __

_____

_____

During your bowel movements, do you have? (Check all that apply)

☐ Dry stool	☐ Loose stool	☐ Diarrhea
☐ Constipation	☐ Straining	☐ Other: _____

How many bowel movements do you have a day? _____

Do you have: (circle all that apply): Gas Bloating Bad breath

Urination:

How often do you urinate a day? _____

Is it difficult to urinate? Yes or No Painful? Yes or No

What color is your urine? (Circle one) Clear Light Yellow Dark Yellow

Do you wake up to urinate? Yes or No If yes, how often? _____

Sleep:

Is it easy for you to fall asleep? Yes or No

Do you wake up during the night? Yes or No How often? _____

On average, how many hours of sleep are you getting a night? _____

Head & Chest:

Do you experience any of the following? (Check all that apply)

- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Asthma/Wheezing
- ☐ Vertigo/Dizziness
- ☐ Sinus problems
- ☐ Brain fog
- ☐ Palpitations
- ☐ Chest pain/Discomfort
- ☐ Chest tightness

Skin:

Do you experience any of the following? (Check all that apply)

- ☐ Sweat easily
- ☐ Sweat at night
- ☐ Sweaty hands & feet
- ☐ Dry skin
- ☐ Rashes
- ☐ Acne or Boils
- ☐ Bruise easily
- ☐ Eczema
- ☐ Other: _____
- ☐ Does your sweat have an odor?

Temperature:

Do you experience any of the following? (Check all that apply)

- ☐ Cold hands
- ☐ Cold feet
- ☐ Hot hands
- ☐ Hot feet
- ☐ Fever
- ☐ Chills
- ☐ Hot flashes
- ☐ Alternating fever and chills
- ☐ Aversion to heat
- ☐ Aversion to cold
- ☐ Other areas hot/cold: _____

Vision, Hearing & Taste:

Do you experience any of the following? (Check all that apply)

- ☐ Blurred vision
- ☐ Night blindness
- ☐ Dry Eyes
- ☐ Watery Eyes
- ☐ Ear ringing
- ☐ Ear aches
- ☐ Popping
- ☐ Muffled hearing
- ☐ Metallic Taste
- ☐ Sweet Taste
- ☐ Sour Taste
- ☐ Bitter Taste
- ☐ Other: _____

Is there anything else that you feel is important and would like us to know? _____

_____

_____

_____

Consent:

I, _____, give the providers of Integrated Muscle & Spine Chiropractic Clinic, Inc. permission to consult with me over the information I have provided in this form. I am allowing the providers to order labs they believe are necessary based off the information I have provided above. I instruct the providers of Integrated Muscle & Spine Chiropractic Clinic, Inc. to deliver the care, that in their professional judgement, can best help me or my child in the restoration of health. I understand that functional medicine/health is a separate and distinct healing art from medicine and does not proclaim to cure any disease or entity. To the best of my ability, the information I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature _____ Date _____