FUNCTIONAL WELLNESS – New Patient Application & Case History Today's Date_____

Name_____Age_____DOB_____ Sex: M F SSN _____-___-_____

Address_____City_____State___Zip _____

Email_____ Home/Cell Phone_____

Occupation/Employer_____Length of employment _____

How did you hear about us? _____

Present Complaints

1. My main health problems are _____

_____

_____

2. Which of your main problems is/are the most concerning? _____

_____

_____

3. You, more than anyone else, know most about your health condition. In your own words and opinion, why do you think your health problems exist?

_____

_____

_____

4. How often are you aware of your health problems?

❑ I never really notice them.

❑ I rarely notice them, maybe monthly.

❑ I notice them sometimes, maybe weekly.

❑ I definitely notice them, maybe daily.

❑ I am constantly dealing with them.

6. Have others noticed or commented on your health? Y N

What have they said? _____

5. How severe are your health problems?

❑ Minimal: I can mostly do whatever I want.

❑ Slight: I can usually push through my day.

❑ Moderate: It's challenging getting through my day. ❑ Severe: I'm having a very difficult time functioning day to day. ❑ Extreme: I can hardly function in my life anymore.

7. Has your health caused you to lose time or miss out from the following? (Please provide a brief description.)

Work? Y N _____

Family? Y N _____

Leisure? Y N _____

Other: _____

8. What measures (diet or exercise programs, counseling, medical programs, Google, WebMD, etc) have you tried?_____

_____ _____

_____

9. If you cannot find a solution to your health problems, what do you think will happen to you? _____

_____

10. List your 3 most important health goals in order of importance:

1._____

2. _____

3. _____

11. Rate your motivation to achieve these goals: 0 1 2 3 4 5 6 7 8 9 10

12. Who is your biggest supporter when it comes to improving your health? _____

Medical and Lifestyle History Current

Medications, Supplements, Vitamins

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently taking insulin? Y N

Blood Sugar (if you are currently monitoring it)

HIGHEST your blood sugar gets WITHOUT medication ____

HIGHEST your blood sugar gets WITH medication ____

LOWEST your blood sugar gets WITHOUT medication ____

LOWEST your blood sugar gets WITH medication ____

Medical History

Surgeries and Hospitalizations Date

_____

_____

_____

_____

Accidents and Traumas Date

Which one(s)?_____

Are you currently diagnosed as pre-diabetic? Y N

Have you had any imaging of your thyroid done recently? Y N Have you received or are you waiting to receive an organ transplant? Y N Are you currently taking antirejection or immunosuppressive medications? Y N

How high would you rate your stress? 0 1 2 3 4 5 6 7 8 9 10

What are the 3 unhealthiest diet choices you make?

_____ _____ _____

What are the 3 healthiest diet choices you make?

_____ _____ _____

What is your current height? _____ft. _____in.

What is your current weight? _____lbs.

Lifestyle

How many alcoholic beverages do you drink per week? ___

Do you smoke? Y N

How many times per day? ___

How many caffeinated beverages do you drink per day? ___

Are you currently vegan or vegetarian? Y N

How many days do you exercise each week? ___

Marital status S / M / W / Sep. / D Spouses Name _____

Children Age

_____

-

_____

-

_____

-

_____

-

_____

-

Family History

_____

_____

_____

Past/Recent Illness Date

_____

_____

_____

_____

Have you been diagnosed with an autoimmune condition? Y N

PART II (next page)

Family Health History (mother, father, siblings, etc

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed			Yes	No

Category VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)		
Are you perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No
Shortened menses, less than every 24 days	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

Doyoueatboxedfood morethantwicea week? Y N

Doyoureceivethefluvaccineannually? Y N

Doyoueat friedfoods? Y N Doyoudrinkanytypeofsoda? Y N

Doyouhaveahistoryorexposureto mold? Y N How manytimesa

Doyoufeelyougetallyourneedednutrientsfrom food? Y N

weekdoyoueat raw nutsorseeds? _____

Doyoudrinkat least4glassesof waterperday? Y N

Doyoufeelyouareagingquickly? Y N

Doyoueat whiteflour, whiterice,or whitebread? Y N

Doyouhavesilveramalgamsinyour mouth? Y N Doyoueatat

least5servingsofvegetablesperday? Y N