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FUNCTIONAL HEALTH

Name_____Date: _____/_____/_____
Address_____
City_____ State_____ Zip_____
Telephone-Home (_____) _____ Mobile (_____) _____
Email_____ Allow Text and/or Email Communications: Y or N
DOB (MM/DD/YY) _____/_____/_____ Age_____ Height____ft____in
Occupation_____ Marital Status: Single Married Widowed Divorced
Emergency Contact Name: _____ Phone: (_____) _____
Who can we thank for referring you to our office? _____
Are you taking any medication? NO YES
If yes, please list medication's name, dosage, and what condition medication is used for:

Medication	Dosage	Condition

if more space is needed, please use back of the page

Do you have any known allergies? NO YES
If yes, please list known allergies: _____
Do you wear a pacemaker? NO YES
Are you pregnant? NO YES Are you breastfeeding? NO YES

MEDICAL HISTORY

Do you or any family member have/had any of the following? Family use "F", personally use "√"

_____Heart Attack
_____Diabetes
(If yes, is it under control? YES NO)
_____Type I _____ Type II
_____ Year of Diagnosis
_____Thyroid Disease
_____ Hypothyroidism
_____ Hashimoto's Thyroiditis
_____ Year of Diagnosis
_____Gallbladder Disease
(If yes, year removed _____)
_____Kidney Disease
_____Stroke
_____Grave's Disease
_____Gout
_____Hypoglycemia
_____Anemia

_____Cancer
_____High Blood Pressure
(If yes, does it require more than 2 medications? YES NO)
_____Low Blood Pressure
_____Weak/Compromised Immune system
Condition: _____
_____High Cholesterol
_____Tension Headaches
How often? _____
_____Migraine Headaches
How often? _____
_____Difficulty getting to sleep
_____Difficulty staying asleep
_____Arthritis
_____Shortness of Breath

_____Intestinal Problems
Name of Condition_____
_____Discomfort After Eating
_____Pain After Eating
_____Gas
_____Bloating
_____Constipation
_____Diarrhea
_____Heart Burn/Reflux/GERD
_____Fatty Liver Disease
_____Polycystic Ovarian Syndrome
_____Ovarian Fibroids
_____Depression
_____Anxiety
_____Low Energy
_____Brain Fog

Primary Care Physician name, phone number and address:

_____

_____

Has your Primary Care Physician recommended you lose weight? NO YES

HISTORY

How long have you been overweight? _____
Can you attribute your weight gain to anything specific? _____
Have you tried to lose weight in the past? NO YES
If yes please list programs/methods: _____

_____

What are your top 2 reasons **WHY** you want to lose weight? _____

_____

What would prevent you from starting our program today? _____

_____

Do you take vitamins or other nutritional supplements? NO YES

If yes, please list below:

_____

_____

_____

What describes you best? I eat too much:
When Nervous _____ For Pleasure _____ When Upset _____ Other: _____

Please take a moment and summarize what you normally eat for:

Breakfast: _____
Mid-Morning: _____
Lunch: _____
Mid-Afternoon: _____
Dinner: _____
Evening: _____

GOALS

What is your current weight? _____ What is your goal weight? _____
When was the last time you were at goal weight? _____
How much have you lost and gained and then lost and gained in the past? _____
On a scale of 1-10, with 10 meaning – I'm fully committed to losing weight and getting healthy, what is your commitment level? 1 2 3 4 5 6 7 8 9 10

Signature_____ Date _____

Internal Use Only:

Conditions

Asthma/COPD
Birth Control
Chronic Auto-Immune Pain Disorder (Fibromyalgia, Rheumatoid Arthritis, Chronic Fatigue, etc.)
Chronic Infection
Chronic Intestinal Disorder (IBS, Crohns, Gastritis, GERD, etc)
Depression
Diabetes
Edema
Gout
Heart Disease (Hypertension, Elevated Cholesterol, Arrythmias, Congestive Heart Failure, etc.)
Hormone Replacement Therapy
Liver Issues (Elevated Triglycerides, Fatty Liver Disease, Hepatitis)
Osteoporosis/Osteopenia
Seizures
Stroke
Thyroid Issues

Medications For Above

❑ 1 ❑ **2** ❑ **3+**

Condition For 1 Year +?

❑ No ❑ **Yes**

Recommendations

❑ 40FA	❑ 40FA DNA	❑ 3FA	❑ 6FA	❑ 9FA	❑ 12FA
❑ 40FR	❑ 40FR DNA	❑ 3FR	❑ 6FR	❑ 9FR	❑ 12FR
❑ 40FU	❑ 40FU DNA	❑ 3FU	❑ 6FU	❑ 9FU	❑ 12FU