Functional Medicine / Nutritional Consultation

Name:____Date:_____________________

Age:_________ Date of Birth:______________________Marital Status: ☐S ☐M ☐D ☐W ☐Other

Home/Mailing Address:____

____

Home Phone:(_____) __________________________ Cell Phone:(_____) __________________________

Email address:____

Occupation:____________________________________Employer:_________________________________

In case of an Emergency – Contact: ________________________________Relationship:_______________

Home Phone:(_____) __________________________ Cell Phone:(_____) __________________________

Most of our patients are referred to us by a caring family or friend. Whom may we thank for referring you to our office? Or how did you hear about us?

____

HEALTH CONCERNS: Please list your top health concerns or complaints that you would like to address:

1)
2)
3)

Are these concerns affecting your quality of life? (Please check all that apply) Work/School: ☐Y ☐N

Recreation: ☐Y ☐N Sleep: ☐Y ☐N Eating: ☐Y ☐N Walking: ☐Y ☐N Sitting: ☐Y ☐N

Exercise/Sports: ☐Y ☐N Intimate/Personal Life: ☐Y ☐N

GENERAL INFORMATION:

Height:____________ Weight:_____________Blood Type:___________# of Bowel Movements/day:__________

Difficulty falling asleep? ☐Y ☐N Difficulty staying asleep? ☐Y ☐N Lightheaded/irritable when hungry? ☐Y ☐N
Crave sugar/salt? ☐Y ☐N Need coffee/sweets 9-11am or 2-4pm? ☐Y ☐N

What time do you eat Breakfast? _____________Usual Breakfast foods:___________________________________

What time do you eat Lunch?________________Usual Lunch foods:______________________________________

What time do you eat Dinner? _______________ Usual Dinner foods:_____________________________________

What times do you eat Snacks? _____________ Usual Snacks:____

List the foods you crave the most:____

Do you have dietary restrictions?☐Y ☐N   Please explain: (vegetarian, gluten / dairy intolerance, Kosher etc.)

____

MEDICAL HISTORY: – Please check all that apply (**P** = Past / **C** = Current):

P / C	**P / C**	**P / C**	**P / C**
☐☐Abdominal Pains	☐☐Excessive Thirst	☐☐Joint Stiffness	☐☐Shakiness
☐☐Ankle/Foot Pain	☐☐Fainting	☐☐Low Back Pain	☐☐Sinusitis
☐☐Blurred Vision	☐☐Fatigue	☐☐Low Blood Pressure	☐☐Slow Heart Rate
☐☐Chest Pressure	☐☐Feel Loss of Control	☐☐Lump in Throat	☐☐Sore Muscles
☐☐Clammy Hands	☐☐Forgetfulness	☐☐Menstrual Irregularities	☐☐Sore Throat
☐☐Confusion	☐☐Frequent Urination	☐☐Nausea/Vomiting	☐☐Sweating
☐☐Constipation	☐☐Headache	☐☐Persistent Cough	☐☐Swollen Joints
☐☐Convulsions	☐☐Hemorrhoids	☐☐Poor Appetite	☐☐Teeth Grinding
☐☐Decreased Sex Drive	☐☐High Blood Pressure	☐☐Poor Circulation	☐☐Tingling in Feet
☐☐Dizziness	☐☐Hip Pain	☐☐Rapid Heart Rate	☐☐Tingling in Hands
☐☐Dry Mouth	☐☐Insomnia	☐☐Neck Pain	☐☐Unusual lumps
☐☐Earaches	☐☐Irritability	☐☐Paralysis	☐☐Weak Muscles

Are you currently under the care of any other provider(s)?

____

Medications: (Please list your current medications, date started, and reason prescribed)

____

____

Supplements: (Please list your current supplements, date started, and reason you are taking them)

____

Have you had blood work performed? ☐Y ☐N   Was your blood work within optimal ranges? ☐Y ☐N

If not, which results were not optimal?____

HABITS:

	Daily	Weekly	Monthly	Never	Amount
Alcohol	☐	☐	☐	☐	________
Coffee	☐	☐	☐	☐	________
Soda	☐	☐	☐	☐	________
Tobacco	☐	☐	☐	☐	________
Rec. Drugs	☐	☐	☐	☐	________

Exercise:	**☐ 5-7x/wk**	**☐ 3-5x/wk**	**☐ 1-3x/wk**	**☐ None**	
Sleep:	**☐ 8+ hrs**	**☐ 7-8 hrs**	**☐ 6-7 hrs**	**☐ 5-6 hrs**	**☐ <5 hrs Sleep**
Meals/day:	**☐ 5+**	**☐ 4**	**☐ 3**	**☐ 2**	**☐ 1**
Water/day:	**☐ 60+oz**	**☐ 40-60oz**	**☐ 20-40oz**	**☐ <20 oz**	

WORK ACTIVITY: ☐Heavy Labor ☐Light Labor ☐Sitting ☐Standing ☐Walking/Moving ☐Driving

DAILY STRESS LEVEL: ☐Extremely High ☐Very High ☐High ☐Medium ☐Low ☐None

WOMEN ONLY:

Is there any chance you might be pregnant? ☐Y ☐N Date of last menstrual cycle: ________________________

Are you experiencing peri-menopause? ☐Y ☐N Reached Menopause ☐Y ☐N

Are you experiencing symptoms? ☐Y ☐N

Do you currently, or have you used any of the following? (please circle all that apply)

Birth Control Pills Hormone Replacement Therapy Hormone IUD Copper IUD Contraceptive Shot

Vaginal Ring Contraceptive Patch Emergency Contraceptive

Length of use of each type? ____

Have you ever had an abnormal PAP? ☐Y ☐N Age of menarche (periods began): ________________________

Age of children (if any): ______________________________ # of pregnancies (if any): _____________________

# of Vaginal Births (if any):_________________________# of C-Sections (if any): __________________________

Please state your health goals and aspirations:

____

Are you interested in the following services? ☐Chiropractic ☐Nutrition ☐Gut Issues ☐Thyroid Dysfunction ☐Weight-loss ☐Cholesterol Management ☐Pain Management ☐Other:______________________________

Are there any additional concerns or questions that you want Dr. Alyssa to address?

____

Client Name (Printed) ____

Parent/Guardian (Printed)____

Client Signature____

Date _______________________________