Functional Nutrition + Functional Neurology

Confidential Patient Information

Personal Information

Title: Mr. Ms. Mrs. Dr. Rev. Prof. other: ___________________________________

Name: ____ Date: _____/_____/_____

First Middle Last

Address: ____ Apt #: _______________

City: ________________________ State: ________ Zip: ___________ Country: __________

Home Phone: (______) ______-_______ Work Phone: (_____) _______-________ Ext: ________

Cell Phone: (______) ______-_______

Birth Date: _____/_____/_____ Age: _____ Sex: Male Female

Email Address: ____

Marital Status: Single Married Widowed Divorced Separated

Spouse's Name: ______________________ Children (Names & Ages): _______________________________

Ethnic Descent or Ancestry: ____

Occupation/Job Title: ____ Work: ________ hours/week

How did you hear about us?

Family/Friend/Coworker: ____________________________ Internet/Website: ______________________

Facebook ___________ Other: ____

Emergency Contact

Last: _________________________ First: ______________________ Middle: __________________

Phone: (______) _____-_____ Ext:____ Relationship: __Spouse __Relative __Friend Other:__________

Physicians

___ I am not currently under the care of any medical physician

Name of primary care physician: ___________________________ Phone Number: ______________________

Personal wellness goals and social history

1. Please list your chief symptoms or health goals in order of decreasing severity or importance, starting with the worst symptoms or most important goal first.

Problem or Goal Ex: Headaches	**Onset**	**Frequency** Ex: 4 times per week	**Severity** Mild / Moderate / Severe

2. When was the last time you were completely healthy? You felt alive? You felt everything was moving in the right direction? ____

3. What do you think happened that caused you to start to feel unhealthy or not 100%? (it could be emotional, physical, etc.) ____

   ____

4. How often do you have bowel movements? __ 2-4x a day __1x a day __1x every other day __Less than 1x every other day

5. Besides your spouse, your kids, your parents, and your job, what do you love? What is your passion? What is one thing you enjoy most that you do? ____

   ____

6. Dietary Habits

   Do you skip meals? __Yes __No

   Do you consume coffee or other beverages like energy/diet drinks, or soft drinks daily? __Yes __No

   If yes, how many servings per day? _________

   Do you have any known food sensitivities (especially shellfish)? __No __Yes:__________________

   Is there anything special about your diet that we should know? __Yes __No

   If yes, please explain: ____

7. How high of a priority is your health on a scale of 1-10, 10 being completely dedicated? _____________

8. How would you rate your current health condition on a scale of 1-10: 1=Disastrous and 10=Great _____

9. What is your ability to make changes in your diet on a scale of 1-10, 10 being completely able? _______

10. What do you consider to be the major causes of stress in your life? (for example: spouse, family, friends, loss of a loved one, work, finances, wedding, legal, etc.): ____________________________________

    Please explain: ____

11. Overall Stress: __None __Moderate __Severe

    Family Stress: __None __Moderate __Severe

    Job Stress: __None __Moderate __Severe

12. Overall sense of wellbeing: __Pleased __Satisfactory __Displeased

13. How many hours on average do you sleep per night? ____________________

    How would you rate your quality of sleep? __Great __Good __Fair __Poor

14. Alcohol: __Do not drink alcohol __Drink Regularly ___ glasses, per _______

15. Tobacco: __Do not use tobacco __Live with a smoker __Quit smoking

    __Smoke/Chew ___times per day

16. Exercise: __Do not formally exercise __Walk occasionally __Exercise ___ days per week

17. Would you consider your current lifestyle: __Healthy or __Unhealthy

18. How much time have you lost from work or school in the past year due to illness or pain?

    __ 0-2 Days __ 3-14 Days __ More than 15 days

Diabetics Only: ___ I am not diabetic

How old were you when you discovered you were diabetic? ___________________________

What is the HIGHEST your blood sugar is WITHOUT medications: ______________________

What is the HIGHEST your blood sugar is WITH medications: __________________________

What is the LOWEST your blood sugar is WITHOUT medications: ______________________

What is the LOWEST your blood sugar is WITH medications: __________________________

What is your A1C level? _________ *If unsure leave blank

Adult Illness(es) Put a C in the box if you currently have the condition or P if you had the condition in the past

☐ ADD	☐ Cystic Kidney Disease	☐ Hypertension	☐ Scoliosis
☐ Alzheimer's	☐ Depression	☐ Influenzal Pneumonia	☐ Seizures
☐ Anemia	☐ Diabetes (insulin dep.)	☐ Liver Disease	☐ Shingles
☐ Arthritis	☐ Diabetes (non-insulin)	☐ Lung Disease	☐ Sleep Apnea
☐ Asthma	☐ Eczema	☐ Lupus Erythema	☐ STD's (unspecified)
☐ Cancer	☐ Emphysema	☐ Mononucleosis/Epstein-Barr	☐ Suicide Attempt(s)
☐ Cerebral Palsy	☐ Eye Problems	☐ Multiple Sclerosis	☐ Thyroid problems

☐ Chicken Pox	☐ Fibromyalgia	☐ Parkinson's Disease	☐ Vertigo
☐ Crohn's/Colitis	☐ Heart Disease	☐ Pneumonia	☐ Yeast, Thrush, or Fungal
☐ CRPS (RSD)	☐ Hepatitis	☐ Psoriasis	☐ Other: ________________
☐ CVA (Stroke)	☐ HIV	☐ Psychiatric Problems	☐ Other: ________________

Current Medication(s) List ANY/ALL medications you are CURRENTLY taking __I do not take any medications

Medication	Dosage	For What Condition?	How long have you taken?

Have you ever taken any medication (over the counter or prescribed) continuously for more than 2 weeks? Examples include Tylenol, Nasonex, antidepressants, etc. If yes, when and what type of medication were you taking? (ONLY list the medications YOU ARE NOT currently taking) ___________________________________

____

____

Surgeries Please write the DATE of the procedure in the blank __ I haven't had any surgical procedures

☐ Angioplasty _______________	☐ Cosmetic _____________	☐ Hysterectomy ___________	☐ Pacemaker Insertion _____
☐ Appendectomy ____________	☐ D&C ________________	☐ Joint Reconstruction _____	☐ Rotator Cuff ____________
☐ Caesarian Section __________	☐ Dental Surgery _______	☐ Joint Replacement _______	☐ Spinal Fusion ___________
☐ Cardiac Catheterization _____	☐ Gall Surgery _________	☐ Knee Repair _____________	☐ Tonsillectomy ___________
☐ Carpal Tunnel Repair ______	☐ Hemorroidectomy _____	☐ Laminectomy ____________	☐ Other: ________________
☐ Coronary Artery Bypass ____	☐ Hernia Repair ________	☐ Mastectomy _____________	☐ Other: ________________

Family History __ I deny having any family health problems

Health problems can be genetic and run in families. Who in your immediate family has/had health problems that affect them? Please provide details. ____

____

____

____

____

____

Dental History

Do you currently have any amalgam, silver, metal, and/or gold fillings? __Yes __No

If yes, how many? ________ If yes, please list which kind(s). ____

If you do not have any fillings, have you had any fillings removed in the last 12 months? __Yes __No

Have you had any dental work done in the last 12 months? __Yes __No

If yes, please explain: ____

ALL Females ONLY: Ob/Gyn

Number of births: ______________ or __N/A

Number of C-Sections: ___________ or __N/A

Number of Miscarriages: ___________________

I __AM pregnant or __ I AM NOT currently pregnant

How many days is/was your menses (ie 6 days)? ____

How many days is/was your current cycle (ie 28 days)? ____

Have you ever used hormonal contraception? __Yes or __No

If yes, When? ___________________________________

Have you ever been diagnosed with fibroids, cysts, or endometriosis? __Yes __No

Pain with menses (past or present)? __Yes __No

Has your period skipped (past or present)? __Yes __No

Was there clotting (past or present)? __Yes __No

Start date of your last menses? ____________

What kind of contraception have you used or currently use?
__Partner Vasectomy __IUD __Diaphragm __Condoms
__Hormones __Tubal Ligation

Hormonal Contraception used or using: __Birth control pills __Patch/Injection __Nuva Ring

Are you using the pill now? __Yes __No If yes, for how long? ___________________________________

In the 2nd half of your cycle, do you have or did you have symptoms of breast tenderness, water retention, or irritability (PMS)? __Yes __No

Date of last Mammogram: ___________________ Normal: __Yes __No

Date of last PAP Test: ______________________ Normal: __Yes __No

Women in Menopause ONLY

Are you in menopause? __Yes __No Age at Menopause: _________________________

Age at Pre-Menopause: ____

Have you had a hysterectomy? __Yes __No If yes: __Complete (ovaries & uterus) __Partial (uterus only)

Date of hysterectomy: ____

Reason for hysterectomy: ____

Do you take: __Estrogen __Ogen __Estrace __Provera __Other:_______________ __None

If you have been on hormone replacement, how long have you been taking it? _____________________

Consent to Exam/Consultation

1. I hereby state that the information provided by me is accurate and whole.
2. I understand that the consultation/exam process does not guarantee that I will be accepted for treatment. The doctor may determine that there is a better course of care for me than what is available at FN2.
3. I understand that all my records and health information are protected, kept confidential and stored in a secure manner.
4. I understand that I am allowed to request a copy of the privacy and patient rights policy of FN2.
5. I understand that the care provided here is not to substitute the care of my primary care physician.
6. I have read, understand and accept the terms of the consent to exam/consultation

Patient Print Name:____________________________ Patient Signature:__________________________ Date: __________

FOR GUARDIANS ONLY – Authorizing care

Guardian Name Print:__________________________ Guardian Signature: ________________________ Date:__________