

WHAT TO EXPECT

FUNCTIONAL MEDICINE

- ✚ Functional medicine is a holistic approach to health in which practitioners attempt to uncover the root cause of symptoms through functional medicine testing and treat problems through natural means.
- ✚ Functional medicine is typically not covered under most commercial insurance plans.
- ✚ Functional medicine is a long-term investment in your health and focuses on optimizing quality of life.

THE FIRST APPOINTMENT

- ✚ Spend roughly 1 hour with Provider reviewing paperwork along with initial exam
- ✚ Review financials with Health Coach
- ✚ Purchase recommended test kits

THROUGHOUT THE TREATMENT PHASE

- ✚ Meet with Health Coach after 1st week. Review binder, ask questions, set goals.
- ✚ Meet with Provider & HC once a month to discuss progress, lifestyle changes, concerns and any results.
- ✚ Modifying how you eat and live is an essential part of our program.
 - To some degree, your lifestyle up to now has led you to the state of health you are currently in.
 - We will almost always instruct our patients to be 100% gluten free, dairy free, and gravitate towards a whole food nutrition plan, focusing on meats, vegetables, and fruits.
 - There will be recommendations for daily supplements to replenish deficiencies, bridge nutritional gaps, and help your body rid harmful toxins.

THE LONG-TERM FUTURE

- ✚ Be an active part of the team – You are your best advocate!! Ask questions, contact us if you think something is not right or you do not know if what you are experiencing is normal. Be engaged in the recommendations you will need to implement at home.
- ✚ The time frame largely depends on how long you have been unwell and how quickly you embrace and implement healthy lifestyle changes. We cannot make lifestyle changes for you or stay consistent with supplements for you. What we can do is help to guide and support you on your journey.
- ✚ Set up meetings with Health Coach to help make lasting lifestyle changes, setting short and long term goals for your own health.
- ✚ For most patients, the first 6 months will end with the following:
 - A fresh set of bloodwork to verify progress
 - A recommendation for a 4-week detox plan
 - A maintenance supplement and lifestyle plan
- ✚ Patients who have been sick for a very long time may not progress rapidly enough to be ready for detox and maintenance at the 6-month mark. These patients will be handled on an individualized basis, and we will continue to work with and support them until their body is ready for those steps.
- ✚ Patients who complete the program will be armed with sufficient information to move forward in a way that maintains their newly found health.

OUR COMMITMENT TO YOU

- ✚ We love contributing to a healthy lifestyle! We will provide resources to educate you on how to eat and live so you and your family can enjoy a high quality of life. We will be available to answer your questions and address your concerns as you move towards a lifetime of good health.

Are you ready to join us in a journey to better health?

Functional Medicine Patient Timeline

Appt 1: New patient appointment - \$350.00 paid at the time of scheduling

- 1-hour appointment with Provider and HC (not all time will be face-to-face with staff)
- Review paperwork and discuss symptoms and treatment goals
- Determine necessary testing, which may include additional test kits
- Schedule a blood draw and a chiropractic adjustment for a future date

Appt 2: FASTING Blood Draw (part of initial package)

Patient homework: Complete recommended test kits at home

- Processing of tests results may take 4-6 weeks

Appt 3: Results discussion with Provider and HC (part of initial package)

- Review test results with copy provided, discuss lifestyle changes, review, and purchase recommended supplements (\$350-\$500.00 per month for the first 3 months)

Appt 4: Follow up with HC about one week after results discussion (\$65.00)

- Review lifestyle changes and supplements, address questions and concerns, set goals.

Appt 5: Follow up with Provider and HC 3-4 weeks after appt 4 (\$100.00)

- Review progress and discuss ongoing lifestyle changes

Appt 6: Follow up with Provider and HC 3-4 weeks after appt 5 (\$100.00)

- Review progress and discuss ongoing lifestyle changes

Patient homework: See emailed progress questionnaire prior to blood draw and return to HC

Appt 7: FASTING Blood Draw (\$25.00), additional testing may also be required (\$25-\$700.00)

Appt 8: Results discussion with Provider and HC (\$100.00)

- Review newest test results, discuss, and tune lifestyle changes, if necessary, review and purchase updated recommended supplements (\$250-\$450.00 per month for an additional 3 months)

Appt 9: Follow-up with Provider and HC 3-4 weeks later (\$100.00)

- Review progress and discuss ongoing lifestyle changes

Appt 10: Follow-up with Provider and HC 3-4 weeks later (\$100.00)

- Review progress and discuss ongoing lifestyle changes

Patient homework: See emailed progress questionnaire prior to blood draw and return to HC

Appt 11: FASTING Blood Draw (\$25.00), additional testing if required (\$25-\$700.00)

Appt 12: Results discussion with Provider and HC (\$100.00)

- Review latest test results with copy provided, discuss progress, address questions and concerns
- Initiate detox protocol and discuss maintenance plan (or further testing/treatment if necessary)
- Detox protocol estimated at about \$600.00. Maintenance/further treatment costs vary per patient.



Financial Policy

Thank you for choosing Sycamore Chiropractic and Nutrition, LLC. We are committed to providing the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship. Please read this carefully and if you have questions, please do not hesitate to ask a member of our team. We require a signature to document that you have read and understand these policies.

INSURANCE

- We must emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.
- A current insurance card must be presented at check in for every visit. If the insurance company that you designate is incorrect, you will be responsible for payment.
- We will not bill another insurance carrier supplied later if it is past the timely filing period for that insurance company. If you are insured by more than one insurance company, our office needs to have all insurance policies on file.
- According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. When we verify that your deductible has not been met, we will collect up to our contracted rate with your insurance company at the time of service. Any amount due after your insurance company processes the claim and notifies Sycamore Chiropractic and Nutrition, LLC will be billed directly to you.
- Co-Payments are due at time of service. Co-payments are a contractual obligation between you and your insurance company. If multiple family members are being seen, they will have a separate charge and co-payment collected as required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, Sycamore Chiropractic and Nutrition will allow you to pay out of pocket at a discounted rate. That amount is due at the time of service.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referrals or authorization for specialty care, lab tests and other services that may be required. Please note physicians follow accepted national guidelines when determining your charges. They must code based upon what services were provided and cannot consider health plan benefits.

BILLING

- We will provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa, Discover, American Express and Apple Pay.

- We will charge your account a \$35 non-sufficient funds charge if your check is returned to us for insufficient funds.
- We appreciate the difficulties involved in divorce and court orders. Sycamore Chiropractic and Nutrition will not participate in disputes between custodial and noncustodial parents regarding our patients who are minors. We will refer to the responsible party as the person who signs the financial policy, for reimbursement of any amounts due.
- Balances are due within 30 days of the first statement unless prior arrangements have been made with the billing department. Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- Staff will be collecting payments at check in on all accounts with balances that are more than 30 days past due. If you are having difficulty paying your bill, please discuss the situation with one of the members of our team.
- Should your account remain outstanding more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to an outside collection agency.
- **Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect that debt. We will make every attempt to set up payment arrangements with families that are going through a financial hardship. If we must refer your account to a collection agency, you may be charged additionally for any collection agency costs incurred. If we must refer collection of the account to an attorney, you may be charged additionally for any attorney fees we incur, including court costs. Please note that if your account is referred to a collection agency or an attorney for collection, the physicians of Sycamore Chiropractic and Nutrition may no longer be able to provide care for you and/or your family. In this case the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

MISSED APPOINTMENTS

- Please notify us as soon as possible if you need to cancel an appointment as someone else may want the time slot reserved for you. **A charge will be billed to your account for missed appointments not cancelled 24 hours in advance.** The charge will be based on the type of appointment and the amount of time allotted for the appointment, **and could be as much as \$75**, and will be charged per patient scheduled. We will attempt to notify you of an appointment within 24 hours of your scheduled visit, but ultimately, it is your responsibility to call us to cancel if you cannot keep your scheduled time. Should missed appointments become habitual, the physicians at Sycamore Chiropractic and Nutrition may choose to no longer care for you and/or your family. In that case, the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

OTHER

- **Forms and letters:** We are happy to fill out any necessary forms required by outside entities. Please contact the office for instructions or feel free to drop the form(s) off to one of our team members at the office. There will be a \$30.00 charge for forms filled out, payable at the time the form is picked up. We ask that you allow 48 hours for the completion of all forms that are presented to Sycamore Chiropractic and Nutrition, LLC.
- **Records:** The charge for record transfer will be made per child in accordance with State of Ohio Records. Please ask at the time you request your records. There is no charge for records faxed to specialists. **All account balances will be collected before records are transferred.**
- **Functional Medicine Patients:** The fee for a two-hour new-patient appointment is \$350.00, to be paid at the time of scheduling the appointment. The new patient appointment may be rescheduled one time at no cost. If you choose to cancel your appointment and not seek services, \$100.00 is non-refundable.

FINANCIAL AGREEMENT

We appreciate your compliance with these policies. We strive to provide excellent, cost-effective care in a never-changing health care environment. We are happy to discuss any questions you have about these policies.

The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service. I certify that the information I have given to Sycamore Chiropractic and Nutrition, LLC is accurate. I hereby authorize Sycamore Chiropractic and Nutrition to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Sycamore Chiropractic and Nutrition all benefits for service rendered.

I have read and understand the Financial Policy from Sycamore Chiropractic and Nutrition. I agree to adhere to the above written policies, and all questions have been answered.

Patient Name (Please Print)

Patient Signature

Date



Sycamore Chiropractic and Nutrition
Designated Privacy Official: 513-773-1214

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Sycamore Chiropractic and Nutrition's Notice of Privacy Practices effective September 21, 2020.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restriction.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?

☐ Yes ☐ No

May we leave a message on your answering machine or on your cell phone?

☐ Yes ☐ No

May we discuss your medical condition with any member of your family?

☐ Yes ☐ No

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____

Date: _____

Witness: _____

Date: _____

Informed Consent to Treat

Thank you for trusting Sycamore Chiropractic and Nutrition with your health! We provide functional medicine counseling, nutritional counseling, chiropractic care, and massage therapy. Because you have chosen to engage one or more of these modalities, we ask you to sign this consent form:

I hereby request and consent to the performance of nutritional therapy and counseling, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy (including but not limited to massage therapy, muscle stimulation, ultrasound, and stretching), and diagnostic X-rays on me and my family members (or on the patient named below for whom I am legally responsible) by Dr. David Boynton, DC, CCEP, or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss my health care needs and the nature and purpose of chiropractic adjustments and other procedures and counseling with Dr. Boynton, DC, CCEP and/or with other office or clinic personnel. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgment, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree if I am pregnant or trying to get pregnant that I will inform the doctor immediately.

Patient Printed Name

Date

Consent to treat a Minor

I _____ (☐ Mother, ☐ Father, ☐ Guardian) give permission to Sycamore Chiropractic and Nutrition to treat my son or daughter or legal dependent. I understand that I do not have to be present with them for every visit.

I understand that I am responsible for all charges that are associated with treatment of the minor for whom I am responsible.

Signature of Parent/Guardian

Date

Instructions for filling out the functional medicine intake form

Thank you for choosing us to assist you in your journey to better health! Our ability to help you depends largely on the completeness and accuracy of information you provide in this form.

Please include even symptoms that you consider minor so that we may have a complete picture of your health. We would like to remind you that all of this information is strictly confidential unless you state otherwise.

- It may take 1-3 hours to fill this form out in its entirety.
- Please download the form to your computer before filling it out. **If you fill it out in a web browser, the information you put in will not be saved.**
- Once you have finished filling it out, please email it to info@sycamorechiro.com.
- Our functional medicine staff will then reach out to you to schedule your appointment and collect the \$350 fee that is due at the time of scheduling.

If you have any questions, please call the office or send an email to info@sycamorechiro.com

We look forward to serving you!



Functional Medicine Intake Form

Patient's Name: _____

How did you hear about our office? _____

Today's Date: _____ Date of Birth: ____/____/____ Age: _____ Gender: ☐ M ☐ F

Address: _____

City: _____ State: _____ Zip Code: _____

Marital status: _____ Cell Phone: _____ Home Phone: _____

Email: _____

Job Title: _____ Hours per week: _____

Nature of Business: _____

Genetic Background: Place a check mark next to your selection(s).

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Northern European ☐ Other: _____

Primary language spoken at home: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact

Name: _____ Relationship: _____ Telephone: _____

Insurance Information

Policy holder's name _____ Policy holder's date of birth _____

Member ID _____ Group ID _____

Relationship of patient to policy holder _____

Person filling out this form: _____ Relationship to patient: _____

Is email a reliable way to communicate with you (the patient)? ☐ Yes ☐ No

Story Page

Name:

Age:

Gender:

Date:

Please tell us your story about your health on this page.

Current Complaints and Concerns

List in a few words the main problems you are having or the purpose for your consultation (fatigue, anxiety, poor exercise tolerance, infertility, thyroid disorder, etc.):

1. _____
2. _____
3. _____
4. _____

Please rate your overall health from 0-10 with 0 being very poor and 10 being excellent: _____

Please rate your energy levels from 0-10 with 0 being very poor and 10 being excellent: _____

What do you most hope to accomplish by working with us?

How long ago did your symptoms begin? _____

When was the last time you felt well? _____

Did something trigger a change in your health/symptoms? _____

How much time have you lost from work/school in the past year due to health problems? _____

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
EX: Headache	May 2006	2 times per week	Acupuncture, Aspirin	Mild improvement

What diagnosis or explanations, if any, have you been given for these concerns?

What health care provider(s) have you seen for these conditions?

What types of treatments have you received for your symptoms and have they been helpful?

What seems to make you feel worse?

What seems to make you feel better?

Are you currently in pain? ☐ Yes ☐ No

Is the source of your pain due to an injury? ☐ Yes ☐ No

If yes, please describe the injury and the date it occurred:

If no, please describe how long you have had this pain and what you believe it is caused by:

Please list all of the areas where you currently have pain

Be as specific as possible with the location (upper, lower, right, left, inner, outer, generalized, etc.), type of pain (aching, sharp, dull, burning, tingling, etc.), and severity (mild, moderate, or severe).

Location: _____ Type: _____ Severity: _____

Location: _____ Type: _____ Severity: _____

Location: _____ Type: _____ Severity: _____

Location: _____ Type: _____ Severity: _____

Location: _____ Type: _____ Severity: _____

Medical History

Blood Type: ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ Unknown

Height (feet/inches): _____ Current weight: _____ Desired weight: _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Childhood History

Were you a full-term baby? ☐ Yes ☐ No If born premature, how many weeks? _____

Were you born naturally or via C-section? ☐ Naturally ☐ C-section

Were you breast-fed? ☐ Yes ☐ No If yes, for how long? _____

When pregnant with you, did your mother: ☐ Smoke ☐ Use drugs ☐ Drink Alcohol ☐ Other

Where did you grow up (town name, general area – farmland, city, near major manufacturing, etc.)? _____

Are you aware of specific toxins you were exposed to as a child? _____

Would you describe your childhood as safe, happy, and healthy? ☐ Yes ☐ No

Were you vaccinated as a child? ☐ Yes ☐ Partially ☐ No Age stopped vaccines: _____

Was your childhood diet high in sugar / soda / junk food? ☐ Yes ☐ No

As a child, were there foods that you had to avoid because they gave you symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Childhood Illnesses

	No	Yes	Age		No	Yes	Age
ADD (Attention Deficit Disorder)	<input type="checkbox"/>	<input type="checkbox"/>		Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Croup	<input type="checkbox"/>	<input type="checkbox"/>		Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>		Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Colic	<input type="checkbox"/>	<input type="checkbox"/>		Strep Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Congenital Problems	<input type="checkbox"/>	<input type="checkbox"/>		Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>		Upset Stomach, Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Colds or Flu	<input type="checkbox"/>	<input type="checkbox"/>		Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>		Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	

Did you have any viruses (mono, hand/foot/mouth, etc.)? _____

Family Medical History

Examples to list in the table below

Thyroid problems	Alzheimer's or Dementia	Celiac Disease	Mental illness (specify)
Diabetes	Drug abuse	Emphysema	Stroke
Heart disease	Seizures / Epilepsy	Environmental sensitivity	Skin disorders
High blood pressure	Crohn's Disease	Genetic disorders	Glaucoma
High cholesterol	Autism	Autoimmune conditions	Bleeding tendency
Cancer (specify type)	ADD / ADHD	Kidney Disease	Asthma
Depression or Anxiety	Arthritis (type)	Liver Disease	Other (specify)

List any illnesses for each family member, suggestions below. If deceased, give cause of death and age at death.

Family Member	Age	Alive	Dead	Illnesses / Cause of Death
Paternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	
Brother(s)		<input type="checkbox"/>	<input type="checkbox"/>	
Sister(s)		<input type="checkbox"/>	<input type="checkbox"/>	
Child(ren)		<input type="checkbox"/>	<input type="checkbox"/>	

Patient History

Accidents or Major Trauma/Injuries (list month and year)

☐ None

Surgeries/Hospitalizations (list month and year and reason)

☐ None

Ever had a cosmetic surgery (specify)? _____

Never	Past	Now	Gastrointestinal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory Bowel Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's or Ulcerative Colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis or Peptic Ulcer Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GERD (reflux) or Hiatal Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Celiac Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Worms or Parasites
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Metabolic/Endocrine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia (low blood sugar)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Resistance or Pre-Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism (low thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism (high thyroid)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hashimoto's or Grave's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia or Bulimia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Binge Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Neurologic / Mood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concussion / Whiplash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia (irregular heartbeat)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Genital & Urinary
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease or Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial Cystitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent UTI / Bladder Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Yeast Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Respiratory
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Skin Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes that don't go away
			Locations:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Miscellaneous
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malaria
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Covid-19
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Never	Past	Now	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis or Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other

Any history of cancer? ☐ Yes ☐ No

Type: _____

Date diagnosed: _____

Current status: _____

Medications and Supplements

Please list all prescription and over the counter medications you are currently taking

Medication	Dose	Frequency	Length of time on it	Reason for taking it
<i>Ex: Ibuprofen</i>	<i>400 mg</i>	<i>2 X a day</i>	<i>1 week</i>	<i>Knee injury</i>

Please list all supplements (vitamins, minerals, meal replacements) you currently take.

Supplement	Brand	Form	Dose/Frequency	Length of Time
<i>Ex: Vitamin D</i>	<i>NOW Foods</i>	<i>Soft gel cap</i>	<i>5000 IU / 1 x daily</i>	<i>6 months</i>

Are you allergic to any medications (list)? _____

Symptom Questionnaire

Check mark any that apply to you

General Health

- | | |
|--|---|
| <input type="checkbox"/> Always thirsty | <input type="checkbox"/> Balance problems / considered clumsy |
| <input type="checkbox"/> Always hungry | <input type="checkbox"/> Handwriting is getting less legible |
| <input type="checkbox"/> Often fatigued or exhausted | <input type="checkbox"/> Hands tremble slightly for no reason |
| <input type="checkbox"/> Worn out by little effort | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Considered sickly or in poor health | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> General weakness / muscle weakness | <input type="checkbox"/> Difficulty sweating |

Musculoskeletal

- | | |
|---|---|
| <input type="checkbox"/> Numbness or tingling anywhere | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> Injure, sprain, or strain easily | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Joint swelling, pain, or stiffness | <input type="checkbox"/> Damp weather bothers you |
| <input type="checkbox"/> Restless legs | <input type="checkbox"/> Muscle cramps or spasms |
| <input type="checkbox"/> Difficulty bending or reaching | <input type="checkbox"/> Aching muscles not due to exercise |

Ears, Nose, Throat

- | | |
|--|--|
| <input type="checkbox"/> Swollen neck glands | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Neck lumps or goiter | <input type="checkbox"/> Prone to snoring |
| <input type="checkbox"/> Sinus congestion / discharge | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Sensitive to odors / fragrances |
| <input type="checkbox"/> Post-nasal drip, frequent throat clearing | <input type="checkbox"/> Ear aches / pains / pressure |
| <input type="checkbox"/> Difficulty swallowing food or pills | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Had tonsils removed | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Excessive mucus | <input type="checkbox"/> Ear discharge or itching |
| <input type="checkbox"/> Frequent hoarseness | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Poor sense of smell / taste | <input type="checkbox"/> Sensitive to loud noises |

Kidneys, Urinary Tract

- | | |
|---|---|
| <input type="checkbox"/> Burning or pain when urinating | <input type="checkbox"/> Difficulty passing urine (weak flow) |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney pain (lower back aching) |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Incontinence (poor bladder control) |
| <input type="checkbox"/> Strong smelling urine | <input type="checkbox"/> Bedwetting |

Head, Brain, Eyes

- | | |
|--|---|
| <input type="checkbox"/> Poor concentration / focus | <input type="checkbox"/> Dry or itchy eyes |
| <input type="checkbox"/> Mental sluggishness / brain fog | <input type="checkbox"/> Eyes red, inflamed, or puffy |
| <input type="checkbox"/> Forgetfulness / poor memory | <input type="checkbox"/> Blurred or double vision |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Floaters or flashers in vision |
| <input type="checkbox"/> Hair loss or dry/brittle | <input type="checkbox"/> Difficulty driving at night |
| <input type="checkbox"/> Thinning eyebrows | <input type="checkbox"/> Frequent or constant twitching |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dark circles under eyes |
| <input type="checkbox"/> Irritated by strong lights | <input type="checkbox"/> Visual hallucinations |
| <input type="checkbox"/> Eye pain or pressure | <input type="checkbox"/> Watery eyes |

Skin

- | | |
|---|---|
| <input type="checkbox"/> Bruise easily / bruises heal slowly | <input type="checkbox"/> Cellulite |
| <input type="checkbox"/> Rashes, hives, frequent itching | <input type="checkbox"/> Bugs love to bit you |
| <input type="checkbox"/> Eczema or Psoriasis | <input type="checkbox"/> Nails are weak, split, or have lines/spots |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fungus on nails, Athlete's Foot |
| <input type="checkbox"/> Dry, cracking, peeling skin | <input type="checkbox"/> Crawling sensation on skin |
| <input type="checkbox"/> Sensitive to fabrics, detergents, etc. | <input type="checkbox"/> Burning on bottom of feet |

Teeth, Mouth

- | | |
|---|--|
| <input type="checkbox"/> Sore or bleeding gums (gingivitis) | <input type="checkbox"/> Sour or metallic taste |
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Chronic bad breath (halitosis) |
| <input type="checkbox"/> Tooth pain/aches | <input type="checkbox"/> Tongue coated |
| <input type="checkbox"/> Problems chewing | <input type="checkbox"/> Frequent canker sores or fever blisters |
| <input type="checkbox"/> Have or had braces | <input type="checkbox"/> Chapped lips (frequent Chapstick) |
| <input type="checkbox"/> Chronically dry mouth | <input type="checkbox"/> Grind teeth when sleeping |

Regular cleaning/care at a dentist? ☐ Yes ☐ No

Floss regularly? ☐ Yes ☐ No

____ Number of cavities

____ Number of root canals

____ Number of metal/mercury fillings

____ Number of implants in your mouth

List any major dental work with your approximate age and any health problems following that work.

Gastrointestinal

Have you ever traveled out of the country? ☐ Yes ☐ No

If so, where and when? _____

Have you ever done wilderness camping? ☐ Yes ☐ No

If so, where and when? _____

Have you ever had severe gastroenteritis or diarrhea? ☐ Yes ☐ No

Have you taken antibiotics in the last year? ☐ Yes ☐ No If yes, how many times? _____

Have you ever taken antibiotics for more than two weeks at a time? ☐ Yes ☐ No

Have you ever had to take antibiotics more than once for a chronic ailment? ☐ Yes ☐ No

Have you frequently been on antibiotics, either as a child or as an adult? ☐ Yes ☐ No

Have you frequently taken NSAIDs (Ibuprofen, naproxen, etc.) as a child or as an adult? ☐ Yes ☐ No

Have you ever been on an acid-reducing medication (Nexium, Prilosec, Pepcid, etc.)? ☐ Yes ☐ No

How often do you have a bowel movement? ☐ 3+ daily ☐ 1-3 daily ☐ 4-6/week ☐ 1-3/week

Mark the following as they apply to your bowel movements:

☐ Medium brown ☐ Dark or black ☐ Greenish ☐ Visible blood ☐ Tan ☐ Color varies
☐ Soft / well-formed ☐ Loose ☐ Firm / hard to pass ☐ Often floats ☐ Consistency varies

Do you have intestinal gas? ☐ Occasionally ☐ Daily ☐ Excessive ☐ Foul-smell ☐ No odor

Mark any that apply to you:

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Abdominal pain, cramps, spasms
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Stomach pain relieved by eating, antacids
<input type="checkbox"/> Feel swollen around abdomen area	<input type="checkbox"/> Unable to totally empty bowels
<input type="checkbox"/> Bloating/pain/cramping after eating	<input type="checkbox"/> Dependent on laxatives
<input type="checkbox"/> Feel full after a small meal	<input type="checkbox"/> Rectal itching or burning
<input type="checkbox"/> Feel hungry 1-2 hours after a large meal	<input type="checkbox"/> Rectal hemorrhoids (bleeding)
<input type="checkbox"/> Digestion seems unusually rapid	<input type="checkbox"/> Jaundice (yellow eyes and/or skin)
<input type="checkbox"/> See undigested food in stool	<input type="checkbox"/> Liver or gallbladder trouble
<input type="checkbox"/> Frequent upset stomach, nausea	<input type="checkbox"/> Forehead pain after overeating
<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Pain in back / right shoulder at night
<input type="checkbox"/> Indigestion, acid reflux, belching	<input type="checkbox"/> Significantly affected by odors such as
<input type="checkbox"/> Burning in lower chest (esp. laying down)	fragrance, cigarettes, auto exhaust, perfumes

Circulatory, Respiratory

- | | |
|---|---|
| <input type="checkbox"/> Swollen ankles / feet | <input type="checkbox"/> Heart palpitations, pounding, racing |
| <input type="checkbox"/> Sensitive to heat / cold | <input type="checkbox"/> Abnormal heart rhythm |
| <input type="checkbox"/> Arms or legs cold or clammy | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Hands/feet go to sleep or tingle | <input type="checkbox"/> Varicose veins / spider veins |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Low exercise tolerance |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Run out of breath easily |
| <input type="checkbox"/> Chest pain, heaviness, tightness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Frequent sighing / deep breaths |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Frequent coughing |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Frequent cold / respiratory infections |

Endocrine, Hormones

Women

Currently pregnant? _____ History of hysterectomy? ☐ No ☐ Yes Date: _____

Number		Number		Number	
	Pregnancies		Abortion		Gestational Diabetes
	Caesarean Deliveries		Living Children		Post Partum Depression
	Vaginal Deliveries		Miscarriage		Breast Fed Babies

Age at first period? _____ Menses frequency? _____ Length? _____

Pain? ☐ Yes ☐ No Clotting? ☐ Yes ☐ No Last menstrual period? _____

Are you in menopause? ☐ Yes ☐ No Age at menopause: _____

Use of contraceptives? If so, what type and for how long? _____

Last PAP test: _____ ☐ Normal ☐ Abnormal

Symptoms/Conditions (mark the ones you have)

<input type="checkbox"/>	Fibrocystic Breasts	<input type="checkbox"/>	PMS	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Vaginal Dryness	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	Fibroids	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	Joint pains
<input type="checkbox"/>	Infertility	<input type="checkbox"/>	Decreased Libido	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Painful Periods	<input type="checkbox"/>	Heavy Periods	<input type="checkbox"/>	Loss of control of urine

Use of hormone replacement therapy? ☐ Yes ☐ No How long? _____

What type? _____

Sexually active? ☐ Yes ☐ No Ever had an STD (specify)? _____

Men

Last prostate specific antigen (PSA) level? _____ ☐ Unknown ☐ Never checked

- | | |
|--|--|
| <input type="checkbox"/> Prostate enlargement or infection | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Change in libido | <input type="checkbox"/> Hernia / lumps in testicles |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Difficulty obtaining/maintaining erection | <input type="checkbox"/> Hesitation when urinating |
| <input type="checkbox"/> Genital pain | <input type="checkbox"/> Loss of control of urine |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Nocturia (night time urination) |

Adrenal / HPA Axis

- | | |
|--|--|
| <input type="checkbox"/> Feel dizzy upon standing | <input type="checkbox"/> Reaction time is slow |
| <input type="checkbox"/> Difficulty making decisions / indecisive | <input type="checkbox"/> Emotional instability |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Blurry vision / poor visual focus |
| <input type="checkbox"/> Listless / groggy, chronic fatigue | <input type="checkbox"/> Easily overwhelmed |
| <input type="checkbox"/> Feel worse if you don't eat often enough (hangry, dizzy, weak, shaky, nauseous, headache, etc.) | |

Emotional Health

- | | | |
|--|------------------------------|-----------------------------|
| Are you happy now? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel your life has meaning and purpose? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you like the work you do? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you believe stress is presently reducing the quality of your life? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you spend most of your time/money to fulfill responsibilities (workaholic)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you spend most of your time alone or in your house without going out? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Check mark the ones that apply to you

- | | |
|---|--|
| <input type="checkbox"/> Frequently keyed up or jittery | <input type="checkbox"/> Do things on sudden impulse |
| <input type="checkbox"/> Startled by sudden noises | <input type="checkbox"/> Withdrawn feeling / feeling lost |
| <input type="checkbox"/> Easily upset, irritated, or stressed | <input type="checkbox"/> Feel alone or sad at a party |
| <input type="checkbox"/> Frequently anxious or worried | <input type="checkbox"/> Usually unhappy or depressed |
| <input type="checkbox"/> Feel hostile or aggressive | <input type="checkbox"/> Cry frequently |
| <input type="checkbox"/> Tremble if someone shouts at you | <input type="checkbox"/> Life looks entirely hopeless |
| <input type="checkbox"/> Become frightened for no reason | <input type="checkbox"/> Emotional numbness |
| <input type="checkbox"/> Awakened by frightening dreams | <input type="checkbox"/> Unable to reason |
| <input type="checkbox"/> Blackouts / Amnesia | <input type="checkbox"/> Difficulty working under pressure |
| <input type="checkbox"/> Ever had a nervous breakdown | <input type="checkbox"/> Hyperactive |

Significant Events

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☒ Yes ☐ No

Roles and Relationships

Do you have children (list ages/gender)? _____

Who is living in your household? _____

Employment/occupations of those living in your household: _____

Resources for emotional support? _____

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other

Stress and Coping

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily stressors: Rate on a scale of 1—10. (1 = minimal stress. 10 = very high stress)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Have you ever sought counseling or psychiatric care? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Prayer ☐ Tai Chi ☐ Other

Hobbies and Leisure activities: _____ Lack of interest in hobbies? ☐ Yes ☐ No

How well have things been going for you?

	Very Well		Fine		Poorly		Does Not Apply	
Overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At school or in your job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In your social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nutritional History

Do you grocery shop? ☐ Yes ☐ No *If no, who does?* _____

Do you cook? ☐ Yes ☐ No *If no, who does?* _____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Do you read food labels? ☐ Yes ☐ No

Check all the factors that apply to your current lifestyle and eating habits

<input type="checkbox"/>	Erratic eating pattern	<input type="checkbox"/>	I dislike healthy food
<input type="checkbox"/>	Late night eating	<input type="checkbox"/>	Family members dislike healthy foods
<input type="checkbox"/>	Love to eat	<input type="checkbox"/>	Family members have special diet needs/desires
<input type="checkbox"/>	Eat because I have to	<input type="checkbox"/>	Eat more than 50% of meals away from home
<input type="checkbox"/>	Have a negative relationship with food	<input type="checkbox"/>	Travel frequently
<input type="checkbox"/>	Emotional eater (eat when sad, lonely, bored)	<input type="checkbox"/>	Don't care to cook
<input type="checkbox"/>	Eat too much under stress	<input type="checkbox"/>	Do not plan meals or menus
<input type="checkbox"/>	Eat too little under stress	<input type="checkbox"/>	Reliance on convenience
<input type="checkbox"/>	Confused about nutrition advice	<input type="checkbox"/>	Poor snack choices
<input type="checkbox"/>	Difficulty gaining weight	<input type="checkbox"/>	Always hungry or thirsty
<input type="checkbox"/>	Difficulty losing weight	<input type="checkbox"/>	Rarely hungry or thirsty

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

The most important thing I should change about my eating habits to improve my health is:

Please list the foods that you normally consume at each meal

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you currently follow any particular diet or nutritional program? ☐ Yes ☐ No

☐ Gluten-Free ☐ Low-Carb ☐ Dairy-Free ☐ Vegetarian ☐ Vegan ☐ Blood Type

Other: _____

Do you avoid any particular foods (type and reason)? _____

If you could only eat a few foods a week, what would they be?

What foods do you dislike? _____

What foods do you crave? _____

How many times do you chew your food? _____

How many servings of fruits and vegetables do you eat per day? _____

What oils do you cook with? _____

Do you eat dessert? If so, what do you eat? _____

Do you have snacks during the day? If so, what do you snack on?

What times do you normally eat?

Breakfast: _____ Lunch: _____ Dinner: _____ Snack: _____

Do you skip meals? ☐ No ☐ Occasionally ☐ Weekly ☐ Daily ☐ Intermittent Fasting

Do you eat while standing up? ☐ No ☐ Sometimes ☐ Often

What types of beverages do you consume? _____

Do you drink coffee? ☐ No ☐ 1 cup/day ☐ 2-4 cups/day ☐ >4 cups/day

Do you drink caffeinated tea? ☐ No ☐ 1 cup/day ☐ 2-4 cups/day ☐ >4 cups/day

Do you drink caffeinated sodas or diet sodas? ☐ No ☐ 12-24 oz / day ☐ >24 oz / day

List favorite type of soda (if any): _____

How much fluid do you drink with meals? _____ How much water do you drink daily? _____

Do you have symptoms immediately after eating? ☐ Yes ☐ No

☐ Belching ☐ Bloating ☐ Drowsiness ☐ Gas ☐ Hives ☐ Sneezing ☐ Other

If yes, are these symptoms associated with any particular food or supplements? ☐ Yes ☐ No

If yes, please specify: _____

Do you feel that you have delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc.? Symptoms may not be evident for 24 hours or more. ☐ Yes ☐ No

Do you feel better or worse or no different if you eat the following foods?

High carb foods (breads, pasta, potatoes) _____ Fried foods _____

High protein foods _____ High fat foods _____

Refined sugar (junk food) _____ Spicy foods _____

1-2 alcoholic drinks _____ Citrus foods _____

Lifestyle History

Smoking, Alcohol, Drugs

Do you currently smoke? ☐ Yes ☐ No

Did you used to smoke? ☐ Yes ☐ No

If yes, how many years? _____ Packs per day? _____

Attempts to quit? _____

Do you use any other tobacco products (specify)? _____

Does anyone in your household smoke? ☐ Yes ☐ No

Are you frequently exposed to second hand smoke? ☐ Yes ☐ No

Rate your history of alcohol intake: ☐ None ☐ Mild ☐ Moderate ☐ High

How many drinks do you consume per week? (*1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*)

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 (If "none," skip to Other Substances below)

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (you can hold more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking alcohol? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Are you currently using any recreational drugs? ☐ Yes ☐ No Type: _____

Have you ever used recreational drugs? ☐ Yes ☐ No Type: _____

Do you have a prescription/card for medical marijuana? ☐ Yes ☐ No

Sleep and Rest

Average number of hours you sleep per night? ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

When do you normally go to bed? _____

☐ Trouble falling asleep

☐ Trouble staying asleep

☐ Often wake up between 1-3am

☐ Do not feel rested in the morning

☐ Need caffeine to really wake up

☐ Nightmares

When do you normally wake up? _____

☐ No dream recall

☐ Problems with snoring

☐ Use sleeping aids

☐ Need or want to sleep during the day

☐ Practice sleep hygiene

☐ Turn off the house WiFi at night

Exercise

Do you exercise regularly? ☐ Yes ☐ No

Do you have a sedentary job? ☐ Yes ☐ No

Describe current exercise habits (walking, weight training, yoga, sports, aerobics, etc.)

Rate your level of motivation for including exercise in your life: ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

Do you usually sweat when exercising? ☐ Yes ☐ No

Environmental

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Radon ☐ Medical Radiation

How many hours a day do you spend on a cell phone? _____ On a computer? _____

Do you notice any symptoms related to electronic device exposure? _____

Do you have a known history of significant exposure to any chemicals/pesticides? ☐ Yes ☐ No

Chemical Name, Date, Length of exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you have any pets or animals? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?

☐ No ☐ Past ☐ Current

Do you or have you ever lived or worked close to a power plant, busy highway, paper mill, steel factory, etc.?

☐ No ☐ Past ☐ Current If yes, please specify: _____ For how long? _____

In what environment (home, work, nature, etc.) do you tend to feel best? _____

In what environment (home, work, nature, etc.) do you tend to feel worst? _____

Other comments about possible environmental exposures throughout the course of your life:

What brands of personal care products do you use? (Deodorant, lotions, soaps, make-up, etc.)

Readiness Assessment

In order to improve your health, how willing are you to:

	Very willing	Somewhat willing	Unsure	Not really willing	Not willing at all
Significantly modify your diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take nutritional supplements each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Modify your lifestyle (work demands, sleep habits, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice relaxation techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in regular exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have periodic lab tests to assess progress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any previous functional medicine testing you have had done.

☐ None

How do you learn best? ☐ Visual / Video ☐ Audio ☐ Reading ☐ Discussion

Any other comments or concerns

End of Functional Medicine Intake Form

Thank you for taking the time to complete this health history medical questionnaire. The information derived from these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. We look forward to helping you achieve lifelong health and well-being!

Yours in Good Health,

Dr. David Boynton and the Sycamore Chiropractic and Nutrition Team