

# Lowcountry Integrative Center - Program Fit Consultation Form

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## Patient Information

Full Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## Primary Condition or Concern

What condition or symptoms are you seeking help for?

\_\_\_\_\_

## Duration of Illness

How long have you been experiencing these symptoms?

\_\_\_\_\_

## Previous Diagnoses or Testing

Have you previously been diagnosed with any of the following?

Lyme disease

Mold illness / CIRS

MCAS

Autoimmune disease

Chronic fatigue syndrome

EBV

COVID-19

Other: \_\_\_\_\_

## Current and/or Previous Care

Are you currently working with another provider for this condition? Yes/No

If yes, who are you currently working with? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you able to commit to the financial investment required for complex chronic illness care? Yes/No

\_\_\_\_\_

Have you previously worked with integrative or functional medicine providers?

Yes / No

If yes, please describe briefly:

\_\_\_\_\_

## Expectations

What are you hoping to achieve through care at the Lowcountry Integrative Center?

\_\_\_\_\_

## Next Step

If appropriate, patients may schedule a Comprehensive Integrative Consultation with Dr. Penni Vachon, APRN.