Date: ______________________

Your Name: ______________________________________ DOB: ______________________

Functional Medicine Intake

Thank you in advance for taking the time to complete. Please omit any sensitive or confusing questions and we can discuss in person as needed. Thank you and see you soon! — Julie Thompson, DO

What would you like to achieve in your first visit? ____

____

Describe your short-term health goals: ____

____

____

____

Describe your long-term health goals: ____

____

____

____

If you had a magic wand and could erase any 3 problems in your life, what would you erase?:

1. ____
2. ____
3. ____

Describe the habits and behaviors you are able to do regularly that support your health: __________________________

____

____

Describe any challenges you face in making changes that support your health: ____________________

____

____

When was the last time you felt well? ____

____

Did something trigger your health change? ____

____

What makes you feel better? ____

____

____

What makes you feel worse? ____

____

____

How would your life change if you achieved optimal health? ___________________________________

____

____

____

Your Name: ____________________________ DOB: ____________________ Date: ____________________

Current health concerns- Please rank in order of priority:

Problem:	Severity: Mild	Moderate	Severe	Prior Treatment:	Effect: Resolved	Improved	Unchanged
Example: diarrhea		*X*		*Avoiding dairy*		*X*	
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

Sleep:

How many hours of sleep do you get each night on average? ____________________

List any sleep medications or aids: ____________________

Do you have challenges falling asleep?	☐Yes ☐No	Do you feel rested upon awakening?	☐Yes ☐No
Do you have challenges staying asleep?	☐Yes ☐No	Do you snore?	☐Yes ☐No
Do you have insomnia?	☐Yes ☐No	Are you often disrupted/awoken?	☐Yes ☐No

Please explain: ____________________

____

Current Exercise program:

Activity	Type	# of times per week	Duration (minutes)
Cardio / Aerobic			
Strength / Resistance			
Flexibility / Stretching			
Balance			
Leisure (e.g. walking, golf)			
Other:			

Do you feel motivated to exercise: ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

List any problems / challenges that limit exercise: ____________________

____

Describe any fatigue or pain experienced with or after exercise: ____________________

____

Your Name: ____________________________ DOB: __________________ Date: __________________

Medication / drug exposures:

Have you used any of the following regularly or for an extended time? Check if yes:

☐ Antibiotics ☐ Acid-blocking drugs (Zantac, Prilosec, Nexium)
☐ Acetaminophen (Tylenol) ☐ NSAIDs (ibuprofen-Motrin/Advil, naproxen-Aleve, Aspirin)
☐ Nicotine (smoke/vape) ☐ THC / marijuana ☐ Oral steroids (prednisone)

Have you had any challenges with substance use or dependence? ☐ No ☐ Yes

Nutrition:

Do you currently follow any of the following diets / nutritional programs? (Check all that apply)

☐ Vegan ☐ Vegetarian ☐ Elimination ☐ Low Fat ☐ Low Carb
☐ High Protein ☐ Low Sodium ☐ No Dairy ☐ No Wheat ☐ Gluten-Free
☐ Low FODMAP ☐ Keto ☐ Other: ____

List any food sensitivities and symptoms: ____
____
____

Who does the cooking in your home: ____

Do you enjoy cooking? ☐ No / never ☐ Sometimes / It's OK ☐ I like it / when I have time ☐ I love cooking

How many meals do you typically eat each day: ________ How many snacks do you typically have in a day: ________

List any symptoms you have when hungry: ____

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

Favorite restaurants: ____

CHECK ALL FACTORS THAT APPLY TO YOUR CURRENT EATING HABITS:	
☐ Fast Eater	☐ Love To Eat
☐ Eat Too Much	☐ Eat Because I Have To
☐ Eat Too Little	☐ Negative Relationship With Food
☐ Late Night Eating	☐ Disordered Eating
☐ Picky Eater	☐ Emotional Eating
☐ Time Constraints	☐ Over-Eat During Stress
☐ Frequent Travel	☐ Under-Eat During Stress
☐ Impulsive Snacking	☐ Cooking Is Challenging
☐ Limited Food Budget	☐ Planning Meals Is Challenging
☐ Eat What My Family Wants / Needs	☐ Confusion About Nutrition Advice

Diet:

Give 2-3 examples of what you eat in a typical day:

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Drinks: ____

Servings per DAY: (1 serving = ½ cup, unless specified)

____Vegetables
____Fruit
____Legumes-beans/soy
____Grains / slice of bread
____Nuts (1 small handful)

Servings per WEEK: (4 ounces unless specified)

____Fish
____Chicken/turkey
____Red Meat (beef/pork)
____Dairy
____# Sweets

____# ounces water/day ____#ounces juice/day ____# ounces soda/sweetened beverage/day
____# ounces coffee/ day ____#ounces tea/day

Your Name: ____________________________ DOB: __________________ Date: __________________

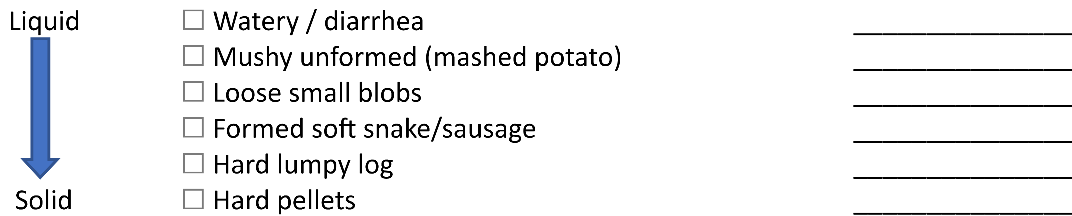
Do you drink any alcohol? ☐ No ☐ Yes If yes, how many drinks per week?_________________

Have you had any worries about or challenges with drinking alcohol? ☐ No ☐ Yes

Digestion:

How often do you move your bowels? ____________________________________

Choose all stool consistencies that you see in a typical month: Frequency / week:



		Frequency / week
Liquid	☐ Watery / diarrhea	____________
	☐ Mushy unformed (mashed potato)	____________
	☐ Loose small blobs	____________
	☐ Formed soft snake/sausage	____________
	☐ Hard lumpy log	____________
Solid	☐ Hard pellets	____________

Choose all symptoms you experience in a typical month:				
☐ Bloating	☐ Cramping	☐ Excessive burping	☐ Excessive gas	☐ Heartburn
☐ Nausea	☐ Abdominal pain	☐ Rectal pain	☐ Urgency to poop	☐ Bloody stool

Other symptoms related to bowels: ____

Factors that cause bowel changes: ____

____

Stress and Resilience:

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

Are you able to easily handle the stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis? *(Rate on scale 1-10, 10 being highest):*

Work____ Family____ Social_____ Finances_____ Health_____ World_____ Other_____

Do you use relaxation techniques? ☐ Yes ☐ No If yes, how often? ______________________

What techniques do you use?: ____

Any current therapy or counseling? ☐ Yes ☐ No If yes, describe: ______________________

Describe any previous counseling / therapy: ______________________________________

People and pets in your home: ____

Do you have resources for emotional support? ☐ Yes ☐ No *(check all that apply)*

☐ Spouse / partner ☐ Family ☐ Friends ☐ Pets ☐ Other: ______________________

Do you have a spiritual / religious practice? ☐ Yes ☐ No

Do you have a history of personal or witnessed abuse (emotional/physical/sexual): ☐ Yes ☐ No

Have you experienced another significant trauma? ☐ Yes ☐ No

Describe the most stressful periods in your life: ______________________________________

____

How have things been going for you recently?

	N/A	Poor			Ok			Good			Great
Overall		1	2	3	4	5	6	7	8	9	10
At your job		1	2	3	4	5	6	7	8	9	10
In school		1	2	3	4	5	6	7	8	9	10
In your social life		1	2	3	4	5	6	7	8	9	10
With your partner/spouse		1	2	3	4	5	6	7	8	9	10
With sex		1	2	3	4	5	6	7	8	9	10
With close friends		1	2	3	4	5	6	7	8	9	10
With your children		1	2	3	4	5	6	7	8	9	10
With your parents		1	2	3	4	5	6	7	8	9	10
With your attitude		1	2	3	4	5	6	7	8	9	10

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