FUNCTIONAL MEDICINE HISTORY

Name ___________________ Date______________

COMPLAINTS/CONCERNS-

____

____

____

____

____

____

____

What do you hope to achieve in your visit with us?____

When was the last time you felt well?____

Did something trigger your change in health? ____

What makes you feel worse? ____

What makes you feel better? ____

PATIENT EARLY HISTORY

☐ Term ☐ Premature ☐ Vaginal Birth ☐ C-section

Pregnancy/Birth Complications: ____

☐ Breast Fed. How long?_______________ ☐ Bottle-fed

Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

Did you need a lot of antibiotics as a child? ☐ Yes ☐ No

Were you happy and secure as a child? ☐ Yes ☐ No Any traumatic events? ☐ Yes ☐ No

MEDICATION

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe:____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics > 3 times/year ☐ Yes ☐ No Long-term antibiotics ☐ Yes ☐ No

Use of steroids (i.e.prednisone) in the past ☐ Yes ☐ No

NUTRITION HISTORY

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

Describe: ____

Do you avoid any particular foods? □ Yes □ No Describe: ________________________

Typical Breakfast____

Typical Lunch____

Typical Dinner____

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

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

____

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

____

PSYCHOSOCIAL

Are you happy? □ Yes □ No   Do you feel your life has meaning and purpose? □ Yes □ No

Do you believe stress is presently reducing the quality of your life? □ Yes □ No

Do you like the work you do? □ Yes □ No Work ____

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

Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No

STRESS

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

Daily Stressors: Rate on scale of 1-10 Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? □ Yes □ No How often? __________

Check all that apply: □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer □ Other: _____

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

Do you have a religious practice? □ Yes □ No

SLEEP/REST

Average number of hours you sleep per night: □ >10 □ 8-10 □ 6-8 □ < 6

Do you have trouble falling asleep? □ Yes □ No   Do you feel rested upon awakening? □ Yes □ No

Do you have problems with insomnia? □ Yes □ No   Do you snore? □ Yes □ No

Do you use sleeping aids? □ Yes □ No Explain: ____

Do you sleep apnea? □ Yes □ No If yes do use CPAP? ____

Typical bedtime:_________________________ Typical wake time:______________________________