



Patient Intake – Functional Medicine

Today's Date: _____

PATIENT INFORMATION

first name

last name

HIPAA PRIVACY:

By signing here you are authorizing you have read and understand your HIPAA rights. Full HIPAA Privacy Disclosure is available at the front desk or online at HeartlandWellnessCenter.com.

➡ HIPAA Signature _____

➡ **COMMUNICATIONS:** **YES** **NO** I authorize Heartland Chiropractic and Wellness Center to leave/send detailed voice mail and/or email messages regarding my appointments, insurance, billing, flexible pending reports, patient communications, including patient care recommendations, etc. with the contact information I provided above.

➡ _____ **Please Initial** you have read the above statement and agree to communications.

AUTHORIZED PARTIES: Who do you authorize HCWC to provide your private healthcare information regarding your **appointment, payments, insurance information, etc.**

parent _____ DOB _____

spouse/partner _____ DOB _____

doctor _____

other _____ DOB _____

Appointment Checklist:

Required

Complete Functional Medicine Intake forms

Recommended

Patient Narrative (no more than 1-2 pages) – “Your Story” Include health history, lifestyle, other treatments or techniques and how you have responded to them.

Labs & Bloodwork

Urine Sample

- first thing in the morning (not middle of the night)
- you're welcome to stop into our office to pick up a sample cup or utilize a clean sample size container from home – glass or plastic. It is not necessary for the sample container to be sterile.

Previous Medical Records

Heartland Chiropractic and Wellness Center

5521 NW 86th St. | Johnston, IA | 50131 | 515.252.8668 | HeartlandWellnessCenter.com

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

What types of therapy have you tried for this problem(s):

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

List current health problems for which you are being treated: _____

Current medications (prescription or over-the-counter): _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

| Year | Surgery, Illness, Injury | Outcome |
|-------|--------------------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

- Corrective lenses Dentures Hearing aid Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations

- move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Strong dislike for any one of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Do you: Prefer warmth (i.e., food, drinks, weather, etc.) Prefer cold (i.e., food, drinks, weather, etc.) No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m. 9 a.m. - 11 a.m. 11 a.m. - 1 p.m.
 1 p.m. - 3 p.m. 3 p.m. - 5 p.m. 5 p.m. - 7 p.m.
 7 p.m. - 9 p.m. 9 p.m. - 11 p.m. 11 p.m. - 1 a.m.
 1 a.m. - 3 a.m. 3 a.m. - 5 a.m. 5 a.m. - 7 a.m.

- 7 a.m. - 9 a.m. 9 a.m. - 11 a.m. 11 a.m. - 1 p.m.
 1 p.m. - 3 p.m. 3 p.m. - 5 p.m. 5 p.m. - 7 p.m.
 7 p.m. - 9 p.m. 9 p.m. - 11 p.m. 11 p.m. - 1 a.m.
 1 a.m. - 3 a.m. 3 a.m. - 5 a.m. 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue Shortness of breath Insomnia Constipation Chronic pain/inflammation
 Depression Panic attacks Nausea Fecal incontinence Bleeding
 Disinterest in sex Headaches Vomiting Urinary incontinence Discharge
 Disinterest in eating Dizziness Diarrhea Low grade fever Itching/rash

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Surgical menopause
- Menopause
- Date of last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
 dairy wheat eggs
 soy corn all gluten
- Other _____

Food Frequency

- Servings per day:
Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Identi-T™ Stress Assessment

Name _____ Age _____ Sex _____ Date _____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1 = Seldom true 2 = Sometimes true 3 = Often true

When under stress for two weeks or longer, I...

Section A:

- 1. Get wound up when I get tired and have trouble calming down..... 0 1 2 3
- 2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
- 3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
- 4. Feel easily overwhelmed by emotion 0 1 2 3
- 5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
- 6. Experience heart palpitations or a pounding in my chest..... 0 1 2 3
- 7. Am short of breath 0 1 2 3
- 8. Am constipated 0 1 2 3
- 9. Feel warm, over-heated, and dry all over 0 1 2 3
- 10. Get mouth sores or sore tongue 0 1 2 3
- 11. Get hot flashes..... 0 1 2 3
- 12. Sleep less than seven hours a night..... 0 1 2 3
- 13. Have trouble falling asleep and staying asleep 0 1 2 3
- 14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
- 15. Forget to eat and feel little hunger..... 0 1 2 3

Total points: _____

Section B:

- 1. Find myself worrying about things big and small 0 1 2 3
- 2. Feel like I can't stop worrying, even though I want to 0 1 2 3
- 3. Feel impulsive, pent up, and ready to explode 0 1 2 3
- 4. Get muscle spasms..... 0 1 2 3
- 5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
- 6. See, hear, and smell things that others do not 0 1 2 3
- 7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
- 8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
- 9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over..... 0 1 2 3
- 10. Worry a lot about terrible things that could happen if I'm not careful..... 0 1 2 3

Total points: _____

Section C:

- 1. Have muscle and joint pains..... 0 1 2 3
- 2. Have muscle weakness 0 1 2 3
- 3. Crave salt or salty things 0 1 2 3
- 4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
- 5. Have dark circles under my eyes 0 1 2 3
- 6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
- 7. Use medications to manage pain 0 1 2 3
- 8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
- 9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
- 10. Have headaches 0 1 2 3

Total points: _____

Section D:

1. Have trouble organizing my thoughts.....0 1 2 3
2. Get easily distracted and lose focus.....0 1 2 3
3. Have difficulty making decisions and mistrust my judgment.....0 1 2 3
4. Feel depressed and apathetic.....0 1 2 3
5. Lack the motivation and energy to stay on task and pay attention.....0 1 2 3
6. Am forgetful.....0 1 2 3
7. Feel unsettled, restless, and anxious.....0 1 2 3
8. Wake up tired and unrefreshed.....0 1 2 3
9. Experience heartburn and indigestion.....0 1 2 3
10. Catch colds or infections easily.....0 1 2 3

Total points: _____

Section E:

1. Feel tired for no apparent reason.....0 1 2 3
2. Experience lingering mild fatigue after exertion or physical activity.....0 1 2 3
3. Find it difficult to concentrate and complete tasks.....0 1 2 3
4. Feel depressed and apathetic.....0 1 2 3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason.....0 1 2 3
6. Have little or no interest in sex.....0 1 2 3
7. Sweat spontaneously during the day.....0 1 2 3
8. Feel puffy and retain fluids.....0 1 2 3
9. Sleep more than nine hours a night.....0 1 2 3
10. Have poor muscle tone.....0 1 2 3
11. Have trouble losing weight.....0 1 2 3
12. Wake up tired even though I seem to get plenty of sleep.....0 1 2 3
13. Have no energy and feel physically weak.....0 1 2 3
14. Am susceptible to colds and the flu.....0 1 2 3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches.....0 1 2 3

Total points: _____

| | |
|-----------------------------------|--------------------------------------|
| Add points from sections A, B & C | Total for A, B & C: _____ |
| Add points from sections C, D & E | Total for C, D & E: _____ |

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
 1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example – spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):

3. I eat breakfast _____ times a week. My typical breakfast is: _____
4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
 Daily 5-6 times per week 3-4 times per week 1-2 times per week Less than once a week
6. I smoke _____ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
 Daily 5-6 times per week 3-4 times per week 1-2 times per week Less than once a week
8. I drink two or more ounces of alcoholic beverages:
 Daily 5-6 times per week 3-4 times per week 1-2 times per week Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

| | | |
|---------------------------|---------------|--------------------------------|
| Current health problem(s) | Date of onset | List all current medication(s) |
| | | |
| | | |
| | | |

