The Pain & Brain Healing Center

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Functional Medicine Patient Intake Form

Dear patient,

This form is to be filled out by those individuals seeking care **from the Pain and Brain Healing Center**. For those individuals with complex chronic disorder (e.g. wide spread pain syndrome, fibromyalgia, depression, digestive disorders, metabolic syndrome, etc.) please take the time to fill this questionnaire out thoroughly. If you have any questions please ask our staff or call us. The first four pages are your health history questionnaire, the six pages to follow are our office policies and procedures please read carefully.

PERSONAL INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____
Home Address: _____City/State/Zip: _____
Phones: (Home) _____ **(Cell)** _____
(Work) _____ **Email** for doctor communications: _____
Age: ___ Birth Date: ____/____/____ Female / Male Occupation: _____
Place of Birth: _____ Race/National/Ethnic Roots: _____
Height: _____ Weight: _____ lbs ___ Right Handed / Left Handed / Mixed Dominance

HEALTH INSURANCE INFORMATION: **Please note → generally we do not take health insurance. We will provide you with a super bill to submit to your insurance for reimbursement.** *

Primary Health Insurance: _____ ID/Group #: _____
Secondary Health Insurance: _____

GENERAL:

Who can we thank for referred you? _____
What do you hope to get from today's visit?
_____
_____

PLEASE DESCRIBE YOUR PRIMARY HEALTH CONCERNS

Is the condition due to injury or sickness arising out of employment? _____
Is the condition due to injury or sickness arising out of an auto or other type of accident? _____
Number of days lost from work _____ Date symptoms appeared or accident happened _____
1. What are the primary problems you are experiencing? _____
_____
_____
_____
2. In the past have you ever had the same or a similar condition? ___yes ___no If yes, please describe: _____
_____
_____
3. Has it changed recently? ___Better ___Worse ___Same What types of treatment have you tried? _____
_____
What makes it better? _____
Worse? _____
4. How frequent is the condition? _____ How long does it last? _____
5. Is this affecting your sleep? ___Yes ___No If yes, please describe: _____
_____

6. Is this affecting your ability to perform your job or daily activities? ___Yes ___ No If yes, please describe: _____
_____
_____

7. Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No
If yes, please describe:
_____
_____
_____

Please list all doctors you have seen related to you current concern, also please include any chiropractors or family medical doctors. If possible list the approximate date of the last visit and their city and telephone number.

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

Please describe any previous tests (X-ray, MRI, EKG, blood work, etc.) to investigate your current problems.
_____
_____
_____
_____

Please mark an "X" on the line to indicate the severity of your condition:

No symptoms
Does not interfere with activities

Extreme symptoms
Disabling

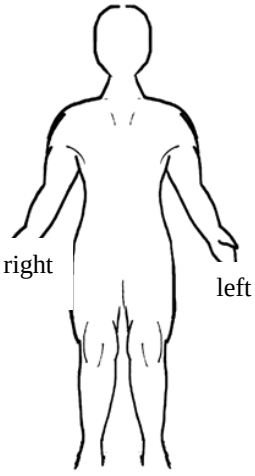
☺----------😐----------☹

0 **5** **10**

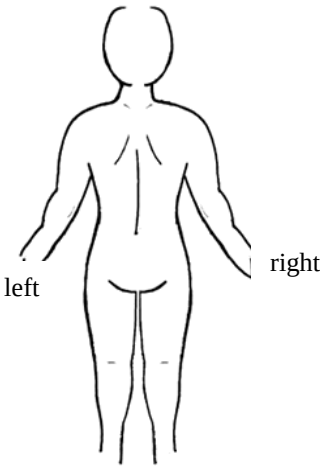
<<<<<<>>>>>>

Please mark any areas of concern on the diagrams below. N – Numbness P- pins & needles B- burning A- aching S-stabbing. Indicate any other problems as best you can.

right side



front



back

left side

List In Order Major Health Problems with Brief Description	DATE OF ONSET	FREQUENCY (Daily, weekly…)	SEVERITY (mild, mod or severe)
1.			
2.			
3.			
4.			

OTC & Prescription MEDICATIONS What drugs are you taking

DRUG NAME	DOSAGE and # per day	Good Response	No Response	Bad Response	Bad then Good

PAST MEDICAL HISTORY

Include any chronic/recurring disorder or previous problems/diseases which no longer affect you

CONDITION	PAST TREATMENTS	CURRENT TREATMENTS	APPROXIMATE DATE (S) of TREATMENT

DIETARY HISTORY

Check the most appropriate description below of my diet:
_____ Mostly carbohydrates (bread, pasta, etc.)
_____ Mostly dairy (milk, cheese, etc.)
_____ Mostly meat
_____ Mostly vegetarian (vegetables, fruits, grains, etc.)
Other Describe: _____

Are you on a Gluten Free Diet ___Yes ___No
Are you on a Dairy Free Diet ___Yes ___No
Have you benefited by being on this diet? _____
Are you on a Low Carbohydrate Diet? _____
Are you on high Omega 3 fatty acid supplementation? ___Yes ___No. Any benefits?_____

Please list the foods and beverages normally consumed by you for three typical days:

DAY 1
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

DAY 2
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

DAY 3
Breakfast: _____
Morning snack(s): _____
Lunch: _____
Afternoon snack(s): _____
Dinner: _____
Other _____

DIGESTIVE HEALTH

Do you have periodic loose stools/diarrhea___ Yes ___ No Offensive Gas ___Yes ___No
Undigested Food in Stools ___Yes ___No Offensive Breath ___Yes ___ No
Do you suffer with acid reflux/heartburn ___Yes ___No
Are you currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___Yes ___ No
Do your digestive problems occur more with stress ___Yes ___No ___ Unsure
Do you produce well formed stools ___Yes ___ No
Have you ever produced formed stools ___Yes ___ No

ANTIBIOTIC HISTORY

How many courses of antibiotics have you received in lifetime (approx): ___ 0 ___ 1-5 ___5-10 ___10-15 ___15-20 ___20+
Main reason for antibiotic use: ___Ear Infections ___Bronchitis ___Pneumonia ___Sinus Infection ___Intestinal Infection ___Other (please explain)_____
Have you ever been treated for a yeast infection following antibiotic use _____

Survey of Your Health History

Please circle all that apply. Indicate whether this is a Current (C) or Past (P) concern also provide an approximate date for past concerns. Indicate severity with 1 mild, 2 moderate, 3 severe.

1. General
Fever
Night sweats
Nervous ness
Bleeding
Diabetes
Thyroid
Headache
Fainting
Depression
Memory loss
Chills
Fatigue
Weight loss/gain
Anemia
Cancer
Substance abuse
Dizziness
Seizures
Phobias
Waking in night
Problems falling asleep
Explain any surgeries or hospitalizations: _____
_____
_____
Any broken bones, car accidents or other injuries? _____
_____

2. Gastrointestinal
belching/gas
vomiting
bloody stools
hernia
constipation
diarrhea
abdominal pain
nausea
liver problems
other_____

3. Respiratory
breathing problems
spitting phlegm/blood
allergies
asthma
shortness of breath
chronic cough
pneumonia
other _____

4. Cardiovascular
irregular heartbeat
racing heart
chest pain
high blood pressure
swelling
prior heart problem
pacemaker
stroke
other _____

5. Musculoskeletal
stiffness
pain
swelling
spinal curve
arthritis
weakness
twitching
tremors
numbness
other _____

6. Skin
rashes
mole changes
itching
nail changes
redness
other _____

7. EENT
blurry vision
double vision
eye pain
jaw pain
hearing loss
ringing in ears
ear infection
sinus problems
nosebleeds
throat problems
speech problems
Glasses or contacts? _____

8. Genitourinary
frequent/painful urination
incontinence
blood in urine or stool
urinary infection
venereal infection
other _____

9. Women Only
difficult periods
hot flashes
irregular cycles
breast pain
lump in breast
difficulty becoming pregnant
complications of pregnancy
other _____
Date last period ended _____
Date last gynecologic exam _____

10. Men Only
testicular pain
prostate problems
difficult erection
low sperm count

11. Exercise
none
1-2 per week
3-4 per week
5-7 per week
What type? _____

12. Habits
Smoke(___packs/day, years?____)
Alcohol (_____ drinks per wk)
Caffeine (_____ cups per day)
Recreational drug use _____

13. Family
Are your parents living? _____
If so do you consider them to be in good health? _____
Ages: Mother _____ Father _____

Circle any below that apply to your parents, siblings or children:
Diabetes
Stroke
Hypertension
Cancer
Seizures
Tremors
Brain disorder
Heart disease
Lung disease
Arthritis
Scoliosis

I, the undersigned, understand that I am financially responsible for all charges. I consent to proceed with the interview and examination. I understand that any treatment will be explained to me and my verbal consent will be requested before any care is rendered.

Signature_____ Date _____