FUNCTIONAL MEDICINE INTAKE FORM

GRACE FAMILY CHIROPRACTIC

PROFILE INFORMATION – STEP 1 OF 4

Please take a moment to fill out our intake form before you visit. All information is kept completely confidential.

Full Name: Preferred Name:

Address: Pronouns:

City: Postal Code:

Home #: Mobile #:

Email: Age: Birth-date: (M) (D) (Y)

Gender: Sex: Personal Health Number:

Refers to current gender which may be different than what is indicated on your insurance policies or medical record.

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Emergency Contact (NAME): Phone#:

Emergency Contact Relationship: Guardian:

Family Doctor: Family Doctor Phone (If Known) :

Family Doctor Email (If Known) :

Name of Referring Professional: Referring Professional Phone (If Known) :

Referring Professional Email (If Known) :

How did you hear about us?

Who were you referred to?

CREDIT CARD INFORMATION – STEP 2 OF 4

Please provide the following credit card information to reserve your appointment time.

Card Number: Date: (M) (D) (Y)

We accept Visa and MasterCard.

Name (as it appears) on Card: Card CVV:

FUNCTIONAL MEDICINE INTAKE FORM

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

Chief Concern 1

Chief Concern 2

Chief Concern 3

Energy & Sleep

Stress & Mood

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

Menstrual History (Female)

Diet & Digestion

- [ ] Breakfast
- [ ] AM Snack
- [ ] Lunch
- [ ] PM Snack
- [ ] Dinner
- [ ] Evening Snack
- [ ] Beverages
- [ ] Heartburn/Reflux?
- [ ] Bloating?
- [ ] Gas?
- [ ] Abdominal Pain?

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

☐ Constipation?

☐ Diarrhea?

☐ Daily Bowel Movement

☐ Other

Physical Activity

Personal Medical History

☐ Date of Last Blood Work

☐ Date of Last Physical (Including PAP)

☐ Allergies

☐ Medications

☐ Supplements

☐ Accidents/Injuries

☐ Surgeries/Hospitalizations

☐ Past Diagnoses/Conditions/Illnesses

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

☐ Smoking

☐ Alcohol

☐ Drugs

Family Medical History

Review of Systems

☐ Headaches

☐ Dizziness/Light-headedness/Fainting

☐ Eyes (vision, dryness, itchiness, floaters/flashers, corrective lenses or surgery)

☐ Ears (pain, discharge, hearing loss, ringing)

☐ Mouth/Throat (tastes, difficulty swallowing, dryness)

☐ Heart Palpitations

☐ SOB

☐ Cough (dry, wet, productive)

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

☐ Chest Pain (can you point to it?)

☐ Numbness/Tingling in Hands

☐ Numbness/Tingling in Feet

☐ Pain (anywhere in body)

☐ Skin (rashes, itchiness, acne)

☐ Urination (does intake = output, blood, pain, difficulty)

☐ Male Genitourinary (erectile difficulty, penile d/c, prostate pain or swelling)

☐ Female Genitourinary (d/c, pelvic, pain, itchiness, redness)

☐ Night Pain

☐ Night Sweats

☐ Weight Gain/Weight Loss

Health Goals

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FUNCTIONAL MEDICINE INTAKE – STEP 3 OF 4

Objective

Assessment

Plan

Future Plan

Next section to be completed by Doctor

FUNCTIONAL MEDICINE INTAKE – CONSENTS – STEP 4 OF 4

Communication

Appointment Notifications and Reminders

Email

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

- ☐ I would like email notifications of new, canceled, and rescheduled appointments
- ☐ Email 24 hours before appointment

Text Message

Standard messaging & data rates may apply, messaging frequency can vary and you can update your preferences anytime.

- ☐ Text Message (SMS) 2 days before appointment
- ☐ Text Message (SMS) 2 hours before appointment

News & Special Promotions

- ☐ Yes, I would like to receive news and special promotions by email

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FUNCTIONAL MEDICINE INTAKE – CONSENTS – STEP 4 OF 4

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree. – *Required*

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee to the card on file.

☐ I am aware of the cancellation policy. – *Required*