SIMPLE

WELL BEING

CHIROPRACTIC | ACUPUNCTURE | NUTRITION

Wilmington NC

FUNCTIONAL MEDICINE ADULT NEW PATIENT INTAKE FORMS

PLEASE BRING THESE FORMS FULLY COMPLETED
TO YOUR FIRST APPOINTMENT

Dr Amanda R. Keates, DC
910-994-2344
www.SimpleWell-Being.com

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Dear Patient,

Welcome! We are happy that you have chosen the path of Functional Medicine to address your health concerns. We believe Functional Medicine offers the best of both worlds: cutting-edge laboratory diagnostics based on the latest scientific research, coupled with lifestyle medicine and ancient wisdom: rest, stress management, diet, nutrition, movement, breathing, quiet time, and botanical and nutritional supplements. We are looking forward to partnering with you to achieve true wellness.

FUNCTIONAL MEDICINE INITIAL CONSULTATION:

In-depth health history intake and consult with Dr. Keates (60 min) Review of body systems Review of relevant FM diagnostic labs Pay for consult, labs, and any supplements purchased Please plan 60 minutes for the initial consult and an additional 15-20 minutes to go over tests and/or supplements

FUNCTIONAL MEDICINE – SECOND CONSULTATION:

Consult with Dr. Keates (30 - 45 min) Review lab results Review personalized treatment program created for you by Dr. Keates Pay for follow-up and any supplements purchased Schedule follow-up appointments

FUNCTIONAL MEDICINE ON GOING CONSULTATIONS:

Consult with Dr. Keates (15 - 30 min) Evaluate progress Review and/or modify treatment program as necessary Pay for follow-up any supplements purchased Schedule follow-up appointments

PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve true wellness.
Itis important to read all of the enclosed information carefully, complete all the forms, and bring them to your first appointment.

WEBSITE

Information about SIMPLE WELL BEING, LLC and all relevant patient forms are available through the website: www.SimpleWell-Being.com

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE

You will begiven a copy of your all of your labs and also uploaded to your portal for you to keep your records. Should you require a letter of medical necessity for any tests or supplements there will be a $30 fee and a one week turn-around time.

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FUNCTIONAL MEDICINE CONSULTATION FEES (2025 Rate, subject to increase 2026)

Initial Consultation with Dr. Keates:	**$200 (45 min)**
Second Consultation with Dr. Keates:	**$150 (30 min)**
Ongoing Consultations with Dr. Keates:	**$150 (30 min)**

LAB TESTS

We do not accept insurance to cover lab tests.

Labs involve stool, urine, saliva, or bloodspot (skin prick) samples some can be done on your own in the comfort of your home, and some you will need to go to other facility and pay for a separate "drawing fee." You will be given all lab kits and step-by-step instructions for home test kits at the time of your consult. Once all of the final lab results are received, we will review them with you at your follow-up visits.

SUPPLEMENTS

All of the supplements that are recommended by Dr. Keates are available for purchase in our office or online through our webstore. Supplements purchased online will be mailed directly to you. Dr. Keates will educate you and recommend foods and nutritional supplements as part of your treatment program, but you are under no obligation to purchase supplements from our office or website.

RETURNS/REFUNDS

Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 1 day of purchase.

CREDIT CARDS

We require a credit card number and at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out. We do not take American Express.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS

There is a 72-hour (3businessdays) cancellation and rescheduling policy for Functional Medicine appointments.

Your appointment must be canceled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a $50 cancellation fee

Your appointment by calling the office at 910-994-2344 or emailing at Dr.Keates@SimpleWell-Being.com phone call to cancel or your email to cancel must be time-stamped no less than 72 hours (3 business days) prior to your appointment time or your credit card will be charged the late cancellation fee.

LATE ARRIVAL APPOINTMENTS

We are committed to being on time with patients' appointments in order to prevent increased waiting times. If you arrive late to the office for your consult, your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW-UP APPOINTMENTS

At the time of check out you will be scheduled for a follow-up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours / 3 business days prior to your scheduled appointment.

PAYMENT OPTIONS

Cash, check, and credit card (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment will be due. Over-the-phone or in-person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account.

INSURANCE INFORMATION

Medical insurance is not accepted for Functional Medicine consults and our office cannot assist you with claim resolution. In addition, Dr. Keates is a Medicare provider.an ABN must be signed that states this is not a covered service. Dr. Keates does not submit her Functional Medicine medical notes to insurance companies.

DISABILITY FORMS

Dr. Keates does not fill out medical disability forms for functional medicine patients, nor does she submit her Functional Medicine medical notes to support disability claims.

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OFFICE HOURS

Our office hours are Monday 9:30 am to 3 pm, Monday through Thursday If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at admin@SimpleWell-Being.com prior to your visit, and notify us of the approximate time you will be stopping in. You may also call it in or text at 910-994-2344

PHONE CALLS AND MESSAGES

Phone messages will be responded to within 24 hours (during business hours). To reach the office, please call 910-994-2344 If you call after hours, please leave a message and the office staff will return your call on the next business day. If you have a medical emergency, call 911 or go directly to the nearest ER.

When leaving a message, please be brief, speak slowly, and include the following information:

- Full name and date of birth
- Reason for call
- Phone number(s) - please repeat this twice
- E-mail address (if desired)

EMAIL

If you would like to schedule / reschedule / cancel an appointment, want to pick up supplements, or have questions about labs or anything administrative, please email at admin@SimpleWell-Being.com if you have a BRIEF medical question for Dr. Keates her at Dr.Keates@SimpleWell-Being.com with the understanding that it can take Dr. Keates up to 72 hours to respond to emails, particularly if it is the weekend.

Wishing you true wellness,

Dr. Keates

she and the Simple Well Being team

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IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- Initial consult is $200 (2025) and ongoing consultations are $175 (2025).
- There is a 72 hour / 3 business day cancellation policy please see cancellation policy in Practice Policies for Patients). We reserve the right to charge your credit card $50 if the appointment is not canceled or rescheduled 72 hours (3 business days) prior to your appointment. By signing below you agree to our cancelation policy and authorize Simple Well Being, LLC to charge your credit card on file for any missed visits.

LAB TESTS & SUPPLEMENTS

- All lab results will be reviewed with you during your second consultation (or whichever consultation immediately follows the time Dr. Keates has received your results from the lab(s), reviewed them, and created your treatment program).
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 1 days of purchase.

RETURN CHECK FEE

- A $35 fee will be assessed for all checks returned for insufficient funds.

BILLING/INSURANCE

- You may request an itemized receipt at the completion of your visit that you may submit to your insurance for HSA account reimbursement. We do not help with insurance claim resolution, as these services are not covered by insurance.
- Payment for the office visit/consultation, phone consultation, or lab tests is expected at time of service. All credit card payments will be processed the same day of the visit or phone consult.
- Simple Well Being, LLC does not accept insurance for Functional Medicine consults.

PRIMARY CARE PHYSICIAN

Please note that Dr. Amanda Keates, DC is not your primary care physician and we recommend that you have a primary care physician.

Patient Signature _____ **Date** _____

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INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Simple Well Being, LLC provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. **Risks:**
    a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients with or without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
    b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Simple Well Being, LLC that all e-mail messages sent or received, which concern the diagnosis, or treatment of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Simple Well Being, LLC will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks.

3. **Consent to the use of e-mail includes agreement with the following conditions:**
    a. All e-mails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, Dr. Keates, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

b. Simple Well Being, LLC practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. We at Simple Well Being will endeavor to read e-mails promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

d. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

e. Simple Well Being, LLC cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication. However, Dr. Keates is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

f. If consent is given for the use of e-mail, it is the responsibility of the patient to inform staff of any type of Simple Well Being, LLC of any information you do not want to be sent by e-mail.

g. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from Oasis Healing Arts, to protect confidentiality. Simple Well Being, LLC is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Simple Well Being at admin@SimpleWell-Being.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Patient Signature _____ **Date** _____

Name Printed _____

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GENERAL INFORMATION

Full Name			
Date of Birth		Age	
Gender	☐ Male	☐ Female	
Highest Education Level	☐ High School	☐ Under-Graduate	☐ Post-Graduate
Job Title			
Primary Address			
Nature of Occupation / Business			
Job Title			
Cell Phone			
Home Phone			
Work Phone			
Emergency Contact			
Phone Number			
Address			
Physician's Name			
Phone Number			

Who Referred you to Dr. Jamie / Oasis Healing Arts?

- ☐ Google (What was your words did you Google search include?) _____
- ☐ Social Media _____
- ☐ Family Member _____
- ☐ Friend _____
- ☐ Other _____

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FUNCTIONAL MEDICINE MEDICAL QUESTIONNAIRE

ALLERGIES

Medication / Supplement / Food

Reaction

COMPLAINTS / CONCERNS

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

If you had a magic wand and could erase three problems, what would they be?

1.
2.
3.

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COMPLAINTS / CONCERNS (Continued)

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?

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READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how willing are you to:

Significantly modify your diet

○	○	○	○	○
5	4	3	2	1

Take several nutritional supplements each day

○	○	○	○	○
5	4	3	2	1

Keep a record of everything you eat each day

○	○	○	○	○
5	4	3	2	1

Modify your lifestyle (e.g., work demands, sleep habits)

○	○	○	○	○
5	4	3	2	1

Practice a relaxation technique

○	○	○	○	○
5	4	3	2	1

Engage in regular exercise

○	○	○	○	○
5	4	3	2	1

Have periodic lab tests to assess your progress

○	○	○	○	○
5	4	3	2	1

Comments

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READINESS ASSESSMENT (Continued)

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related Activities?

○	○	○	○	○
5	4	3	2	1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

○	○	○	○	○
5	4	3	2	1

Comments

Health Screening

SKIN & HAIR PROBLEMS

- ☐ Acne on Face
- ☐ Acne on Body
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Hair Loss
- ☐ Hives
- ☐ Jock Itch
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Rash
- ☐ Red Face / Ears
- ☐ Sensitivity to Insect Bites
- ☐ Shingles
- ☐ Strong Body Odor
- ☐ Sweating - Excessive
- ☐ Sweating - None
- ☐ Villigo

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Health Screening (Continued)

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
- ☐ Hair
- ☐ Hands
- ☐ Mouth/Throat
- ☐ Scalp
- ☐ Skin in General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Ridges
- ☐ Soft

Thickening of:

- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Cough-Dry
- ☐ Cough-Production
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Hay Fever, seasonal
- ☐ Hay Fever, perennial (all year)
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palptations
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

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Health Screening (Continued)

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

SYMPTOM REVIEW

Please check all symptoms experienced within the past 6 months to the present.

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Askep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Small
- ☐ Distorted Taste
- ☐ Ear Puliness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Eye Pain
- ☐ Hearing Problems
- ☐ Headaches
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ White problems (after
- ☐ than glasses)
- ☐ Muscle/Depersiration

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SYMPTOM REVIEW (Continued)

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Cart Courage
- ☐ Chest Tightness
- ☐ Foot Cranps
- ☐ Joint Delormity
- ☐ Joint Pain
- ☐ Joint Defenses
- ☐ Joint Staffions
- ☐ Muscle Pain
- ☐ Muscle Systems
- ☐ Muscle Staffions
- ☐ Muscle Twitches – eyes
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD / NERVES

- ☐ Anxiety
- ☐ Disposal
- ☐ Depression
- ☐ Dizziness / Viering
- ☐ Fartnings
- ☐ Fearfulness
- ☐ Irritability
- ☐ Lightheadedness
- ☐ Nummeres
- ☐ Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tremor/Trembling

Difficulty:

- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Speech
- ☐ With Memory

EATING

- ☐ Blinge Eating
- ☐ Burrilla
- ☐ Cart Gain Weight
- ☐ Cart Lose Weight
- ☐ Cart Maintain Healthy Weight
- ☐ Requeat Dating
- ☐ Poor Appetite
- ☐ Self Cravings
- ☐ Carbohydrate/Craving (breaks, peelas)
- ☐ Chocolate Cravings
- ☐ Sweet Cravings (candy, cookies, cakes)

DIGESTION

- ☐ Axel Spasms
- ☐ Bud Trach
- ☐ Bleeding Guns
- ☐ Bowing
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burning
- ☐ Cariver Sones
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cenema
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flawlence/Gas
- ☐ Fixtures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Healtharm
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Hauses
- ☐ Vomiting
- ☐ Liver Diseases/Jaunofree
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Bone Tongue
- ☐ Strong Stool Odor
- ☐ Unaligned Food in Shools
- ☐ Alternating Diarrhea and Constipation

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SYMPTOM REVIEW (Continued)

Intolerance to:

- ☐ Latches
- ☐ All Only Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

Do you dry clean your clothes frequently?	☐ Yes	☐ No
Do you or have you lived or worked in a damp or moldy environment?	☐ Yes	☐ No
Do you have any pets or farm animals?	☐ Yes	☐ No
Are you satisfied with your sex life?	☐ Yes	☐ No

How well have things been going for you?	**Very Well**	**Fine**	**Poorly**	**Does Not Apply**
Overall in your life	☐	☐	☐	☐
At school	☐	☐	☐	☐
In your job	☐	☐	☐	☐
In your social life	☐	☐	☐	☐
With your friends	☐	☐	☐	☐
With sex	☐	☐	☐	☐
With your spouse / significant other	☐	☐	☐	☐
With your children	☐	☐	☐	☐
With your parents	☐	☐	☐	☐
With having a positive attitude	☐	☐	☐	☐

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ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, list all

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches & Pains

Do you adversely react to any of the following?

☐ Monosodium glutamate (MSCs)
☐ Aspartame (Nutrasweet)
☐ Caffeine
☐ Garlic
☐ Onion
☐ Cheese
☐ Citrus Foods
☐ Chocolate
☐ Alcohol
☐ Red Wine
☐ Sulfite Containing Foods (wine, dried fruit, salad bars)
☐ Preservatives (ex. sodium benzoate)
☐ Cigarette Smoke
☐ Perfumes/Colognes
☐ Auto Exhaust Fumes
☐ Other: _____

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

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ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT (Continued)

Do you have a known history of significant exposure to any harmful chemicals such as the following:

- ☐ Herbicides
- ☐ Insecticides (frequent visits of exterminator)
- ☐ Pesticides
- ☐ Organic Solvents
- ☐ Heavy Metals
- ☐ Other: _____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?	☐ Yes	☐ No
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
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
Would you describe your experience as a child in your family as happy and secure?	☐ Yes	☐ No

STRESS/COPING

Have you ever sought counseling?	☐ Yes	☐ No
Are you currently in therapy?	☐ Yes	☐ No

Describe:

Do you feel you have an excessive amount of stress in your life?	☐ Yes	☐ No
Do you feel you can easily handle the stress in your life?	☐ Yes	☐ No

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STRESS/COPING (Continued)

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 ☐ Imagery ☐ Other: _____

☐ Meditation ☐ Breathing

☐ Prayer ☐ Tai Chi

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ 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

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ROLES/RELATIONSHIPS

Marital status:

☐ Single ☐ Divorced ☐ Widow
☐ Married ☐ Long Term Partnership

# of Children _____

Age of Each Child

Who else is living in household?

Under what circumstances? (ex: my mother - dementia)

Resources for emotional support? *(Check all that apply)*

☐ Spouse ☐ Friends ☐ Pets
☐ Family ☐ Religious/Spiritual ☐ Other: _____

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ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, or 1.5 ounces spirits

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

If "None," skip to Other Substances

Previous alcohol intake?

☐ None ☐ Yes (☐ Mild ☐ Moderate ☐ High)

Have you ever been told you should cut down your alcohol intake?	☐ Yes	☐ No
Do you ever feel guilty about your alcohol consumption?	☐ Yes	☐ No
Do you notice a tolerance to alcohol (can you "hold" more than others)?	☐ Yes	☐ No
Have you ever been unable to remember what you did during a drinking episode?	☐ Yes	☐ No
Do you get into arguments or physical fights when you have been drinking?	☐ Yes	☐ No
Have you ever been arrested or hospitalized because of drinking?	☐ Yes	☐ No
Have you ever thought about getting help to control or stop your drinking?	☐ Yes	☐ No

OTHER SUBSTANCES

Caffeine Intake:		☐ Yes	☐ No
Coffee cups/day:	☐ 1	☐ 2-4	☐ >4
Tea cups/day:	☐ 1	☐ 2-4	☐ >4
Caffeinated Sodas or Diet Sodas Intake:		☐ Yes	☐ No
12-ounce can/bottle per day	☐ 1	☐ 2-4	☐ >4
Are you currently using any recreational drugs (marijuana, ecstasy, etc)?		☐ Yes	☐ No

Type _____

Have you ever used IV recreational drugs?	☐ Yes	☐ No

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EXERCISE

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

Activity	Type	Frequency / Week	Duration in Mins.
Stretching			
Cardio / Aerobics			
Strength			
Other			
Sports or Leisure Activities *(golf, tennis, rollerblading, etc)*			

Rate your level of motivation for including exercise in your life?

☐ Low ☐ Medium ☐ High

List problems that limit activity

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe

Previous Smoking:

How many years?	
Packs per day?	
Second Hand Smoke Exposure?	

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NUTRITION HISTORY

Have you ever had a nutritional consultation? ☐ Yes ☐ No

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

Describe: _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat
☐ Low Carbohydrate
☐ High Protein
☐ Low Sodium
☐ Diabetic
☐ No Dairy
☐ No Wheat
☐ No Gluten
☐ Vegetarian
☐ Vegan

Specific Program for Weight Loss/Maintenance Type: _____

Other _____

Height (feet/inches): _____ Current Weight: _____

Usual Weight Range +/- 5 lbs: _____ Desired Weight Range +/- 5 lbs: _____

Highest adult weight: _____ Lowest adult weight: _____

Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No

Body Fat %: _____

How often do you weigh yourself?

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid any particular foods? ☐ Yes ☐ No

If yes, types and reason:

Do you grocery shop? ☐ Yes ☐ No

If no, who does the shopping?

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NUTRITION HISTORY (Continued)

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No

If no, who does the cooking?

How many meals do you eat out per week? *meals per week*

☐	☐	☐	☐
0-1	1-3	3-5	>5

Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than 50% meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Significant other or family members have special dietary needs or food preferences
- ☐ Love to eat
- ☐ Have a negative relationship with food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely depressed, bored)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutrition advice
- ☐ Significant other or family members don't like healthy foods

SMOKING

Currently Smoking? ☐ Yes ☐ No

How many years?	
Packs per day	
Attempts to quit	

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MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE *(mo/yr)*	REASON FOR USE

PREVIOUS MEDICATIONS: *(Last 5 years)*

MEDICATION	DOSE	FREQUENCY	START DATE *(mo/yr)*	REASON FOR USE

NUTRITIONAL SUPPLEMENTS *(VITAMINS / MINERALS / HERBS / HOMEOPATHY)*

SUPPLEMENT & BRAND	DOSE	FREQUENCY	START DATE *(mo/yr)*	REASON FOR USE

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MEDICATIONS (Continued)

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 prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blockers (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics (> 2 times/year) ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

MEN'S HISTORY (for men only)

☐ Prostate Enlargement
☐ Prostate infection
☐ Change in Libido
☐ Impotence
☐ Difficulty Obtaining an Erection
☐ Difficulty Maintaining an Erection
☐ Urgency/Frequency/Change in Urinary Stream
☐ Loss of Control of Urine
☐ Nocturia (urination at night)
How many times at night? _____

GI HISTORY

Foreign Travel? ☐ Yes ☐ No
Where? _____

Wilderness Camping? ☐ Yes ☐ No
Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

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DENTAL HISTORY

Silver Mercury Fillings: ☐ Yes ☐ No

How many? _____

☐ Gold Fillings

☐ Root Canals If yes, how many? _____

☐ Implants If yes, how many? _____

☐ Tooth Pain

☐ Bleeding Gums

☐ Gingivitis

☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

HOSPITALIZATIONS

☐ None

Date	Reason

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GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY

(Check box if yes and provide number)

- ☐ Pregnancies _____
- ☐ Miscarriage _____
- ☐ Postpartum Depression
- ☐ Baby Over 8 Pounds
- ☐ Caesarean _____
- ☐ Abortion _____
- ☐ Toxemia
- ☐ Breastfeeding For how long? _____
- ☐ Vaginal deliveries _____
- ☐ Living Children _____
- ☐ Gestational Diabetes

MENSTRUAL HISTORY

Age at First Period		Menses Frequency		Length	

Pain: ☐ Yes ☐ No

Clotting: ☐ Yes ☐ No

Has your period ever skipped? ☐ Yes ☐ No

For how long?		Last Menstrual Period	

Use of hormonal contraception such as:

☐ Birth Control ☐ Pills ☐ Patch ☐ Nuva Ring

For how long?	

Do you use contraception? ☐ Yes ☐ No

☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

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WOMEN'S DISORDERS / HORMONAL IMBALANCES (for women only)

- ☐ Fibrocystic Breasts
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Infertility
- ☐ Painful Periods
- ☐ Heavy periods
- ☐ PMS

Last PAP Test: _____ ☐ Normal ☐ Abnormal

Are you in menopause? ☐ Yes ☐ No

Age at Menopause: _____

- ☐ Hot Flashes
- ☐ Mood Swings
- ☐ Concentration / Memory Problems
- ☐ Vaginal Dryness
- ☐ Decreased Libido
- ☐ Heavy Bleeding
- ☐ Joint Pains
- ☐ Headaches
- ☐ Weight Gain
- ☐ Loss of Control of Urine
- ☐ Palpitations
- ☐ Use of hormone replacement therapy

How long? _____

RESPIRATORY DISEASES

- ☐ Asthma _____
- ☐ Chronic Sinusitis _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Pneumonia _____
- ☐ Tuberculosis _____
- ☐ Sleep Apnea _____
- ☐ Other _____

SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Melanoma _____
- ☐ Skin Cancer _____
- ☐ Other _____

NEUROLOGIC / MOOD

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Bipolar Disorder _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD _____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ ALS _____
- ☐ Seizures _____
- ☐ Other _____

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INJURIES

Check box if yes: ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones

SURGERIES

Check box if yes and provide date of surgery

☐ Appendectomy _____
☐ Hysterectomy +/- Ovaries _____
☐ Gall Bladder _____
☐ Hernia _____
☐ Tonsillectomy _____
☐ Dental Surgery _____
☐ Hypoglycemia _____
☐ Metabolic Syndrome _____
☐ Insulin Resistance or Pre-Diabetes _____
☐ Hypothyroidism (low thyroid) _____
☐ Hyperthyroidism (overactive thyroid) _____
☐ Polycystic Ovarian Syndrome (PCOS) _____
☐ Joint Replacement –Knee/Hip _____
☐ Spinal Surgery _____
☐ Heart Surgery–Bypass Valve _____
☐ Angioplasty or Stent _____
☐ Pacemaker _____
☐ Other _____
☐ Infertility _____
☐ Frequent Weight Fluctuations _____
☐ Bulimia _____
☐ Anorexia _____
☐ Binge Eating Disorder _____
☐ Night Eating Syndrome _____
☐ Eating Disorder (non-specific) _____
☐ Other _____

CANCER

☐ Lung Cancer _____
☐ Breast Cancer _____
☐ Colon Cancer _____
☐ Ovarian Cancer _____
☐ Prostate Cancer _____
☐ Skin Cancer _____
☐ Other _____

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GENITOURINARY

- ☐ Kidney Stones _____
- ☐ Gout _____
- ☐ Interstitial Cystitis _____
- ☐ Frequent Urinary Tract Infections _____
- ☐ Frequent Yeast Infections _____
- ☐ Erectile and/or Sexual Dysfunction _____
- ☐ Other _____

MUSCULOSKELETAL / PAIN

- ☐ Osteoarthritis _____
- ☐ Fibromyalgia _____
- ☐ Chronic Pain _____
- ☐ Other _____

INFLAMMATORY / IMMUNE

- ☐ Chronic Fatigue Syndrome _____
- ☐ Autoimmune Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus SLE _____
- ☐ Immune Deficiency Disease _____
- ☐ Herpes-Genital _____
- ☐ Severe Infectious Disease _____
- ☐ Poor Immune Function _____
- ☐ Food Allergies _____
- ☐ Environmental Allergies _____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Latex Allergy _____
- ☐ Other _____

Please list top three current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

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INFLAMMATORY / IMMUNE (Continued)

Prior Treatment / Therapeutic Approach	Excellent	Good	Fair
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

MEDICAL HISTORY - DISEASES / DIAGNOSIS / CONDITIONS

Check the box next to the conditions you have and provide date of onset

GASTROINTESTINAL

☐ Irritable Bowel Syndrome _____
☐ Inflammatory Bowel Disease _____
☐ Crohn's Disease _____
☐ Ulcerative Colitis _____
☐ Gastritis or Peptic Ulcer Disease _____
☐ GERD (reflux) _____
☐ Celiac Disease _____
☐ Constipation _____
☐ Loose Stools _____
☐ Bloating _____
☐ Flatulence (gas) _____
☐ Other _____

CARDIOVASCULAR

☐ Heart Attack _____
☐ Other Heart Disease _____
☐ Stroke _____
☐ Elevated Cholesterol _____
☐ Arrythmia (irregular heart rate) _____
☐ Hypertension (high blood pressure) _____
☐ Rheumatic Fever _____
☐ Mitral Valve Prolapse _____
☐ Other _____

METABOLIC / ENDOCRINE

☐ Type 1 Diabetes _____
☐ Type 2 Diabetes _____
☐ Weight Gain _____
☐ Weight Loss _____