Dr. Guy's Functional Medicine Intake Questionnaire

General Information

Name _____ Age _____ Today's Date_____

Date of Birth _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other: _____

When, where, and from whom did you last receive medical or health care? _____

_____

Emergency Contact: _____ Relationship: _____

Phone (Home) _____ (Cell) _____ (Work) _____

Reason For Visit:

_____
_____
_____
_____
_____
_____
_____
_____

Any additional health concerns:

_____
_____
_____
_____
_____
_____
_____
_____

Past & General History

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your past history, medication history, injury, and surgical history.

Past History: (please list any other past health issues or conditions)

Musculoskeletal Issues: _____

Neurological Issues: _____

Head, Eyes, Nose, Throat Issues: _____

Cardiovascular Issues: _____

Respiratory Issues: _____

Bladder or Bowel Issues: _____

Skin Issues: _____

Autoimmune Conditions: _____

Medication History: (please list any medications you are currently taking)

_____

_____

What other Supplements or Vitamins are you taking?

_____

_____

Injury and Surgical History:

What, if any, major injuries have you had? When?

_____

_____

Have you ever been hospitalized or had surgery? If so, when and why?

_____

_____

_____

_____

Family & Social History

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your family history, social history, and daily activities.

Family History Information:

Please list any conditions or health issues anyone in your family currently has, or has had in the past:

_____

_____

_____

_____

Social History:

Please describe your social history:

Do you use alcohol, caffeine, illicit drugs, or tobacco products? _____

Do you exercise, if so how often? _____

Do you sleep well? How many hours a night? _____

Describe your diet? _____

Describe your job? _____

Daily Activities:

So that we may have an idea as to your daily routine, please list a few of your daily activities and your favorite hobbies: _____

_____

Does your current condition affect your performance in these activities or hobbies?

☐ Yes ☐ No If "Yes", How? _____

Primary Care Physician: _____ PCP Phone: _____

Last Seen: _____/_____/_____ May We Update Them On Your Condition? ☐ Yes ☐ No

Readiness Assessment and Health Goals

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 record of everything you eat each day:	☐5 ☐4 ☐3 ☐2 ☐1
Modify your lifestyle (e.g., work demands, sleep habits, etc.):	☐5 ☐4 ☐3 ☐2 ☐1
Practice relaxation techniques:	☐5 ☐4 ☐3 ☐2 ☐1
Engage in regular exercise:	☐5 ☐4 ☐3 ☐2 ☐1

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 follow through? _____

_____

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

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email Correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐5 ☐4 ☐3 ☐2 ☐1

Comments: _____

_____

_____

Health Goals:

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 better? _____

_____

_____

What make you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____