InSight Health & Wellness

Your Health is Our Vision

Functional Medicine New Patient Application

PLEASE ANSWER ALL QUESTIONS. IF THE QUESTION DOES NOT APPLY TO YOUR SITUATION PLEASE PUT "N/A" NEXT TO THE QUESTION.

Name_____ **Age**_____ **Sex:** M F **DOB**_____**Date**_____

Address_____ **City**_____**State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Email: _____ May we leave a voice mail on your phone? Y N

Height_____ **Weight**_____ **SSN**:_____

How did you hear about us? _____

Employer _____**Occupation**_____ **Length of Employment**_____

Present Complaints

1. **Main Problem(s):**

_____

_____

2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real cause may be?:

_____

_____

3. When were you diagnosed with your present condition(s)?: _____

4. What diagnostic tools were used to achieve your diagnosis (ex: blood tests, X-Rays, MRI etc.)?:

_____

5. What are the 3 things your condition has caused you to miss most in your life?

1._____
2. _____
3._____

6. Symptoms (please list all):

_____

_____

_____

7. Severity of problem (circle one):

Minimal (annoying but causing no limitation)

Slight (tolerable but causing a little limitation)

Moderate (sometime tolerable but definitely causing limitation)

Severe (causing significant limitation)

Extreme (causing near constant limitation (>80% of the time)

8. What aggravates your symptoms or causes them to return?

_____

9. Describe the first time you remember having symptoms:

_____

10. If your symptoms include pain:

What is the quality (sharp, dull, stabbing, color, etc)_____

Does the pain radiate? Y N Where: _____

11. Do your symptoms occur at a specific time, place, or environment? Yes No

_____

When and for how long do symptoms last each episode?:_____

12. What types of treatment have you received?

Prescription/ Drug Therapy_____

Nutritional _____

Alternative/Holistic_____

13. List all your health goals in order of Importance:

_____

_____

_____

14. Motivation to achieve these goals: SCALE: **(1: not motivated - - 10: very motivated)**

Please circle a number: 1 2 3 4 5 6 7 8 9 10

15. What are you hoping happens today as a result of your consultation?

_____

16. How often are you aware of your main problem ?(circle one):

Occasionally (25% of the time)

Frequently (75% of the time)

Intermittently (50% of the time)

Constantly (100% of the time)

17. If you cannot find a solution to your problem what do you think will happen?

_____

18. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work: **Y N** Describe:_____

Family **Y N** Describe:_____

Leisure **Y N** Describe:_____

19. Medication: (List all prescriptions and over-the-counter medications)

_____ _____

_____ _____

_____ _____

Please list past or present allergies, including allergies to medications.

_____

20. Nutritional Supplements: (List all botanicals, herbs, homeopathic, and supplements)

_____ _____

_____ _____

_____ _____

21. What is your employment history? Please provide brief summary including dates if possible.

_____

_____

22. Please list your past or present Hobbies that could be sources of toxicity or chemicals:

_____

_____

23. How often are you involved in these Hobbies currently?

_____

_____

24. Medical and Social History:

Surgeries and Hospitalizations Date(s)

_____

Trauma Date(s)

_____

Past and Recent Illnesses Date(s)

_____

25. Marital Status: Single Married Widowed Separated Divorced

Spouse: _____ __ Children/ Ages: _____

Living with: Spouse Partner Parents Children Friends Alone

26. Family Health History: (mother, father, siblings, spouse, children)

_____

27. Do you use:

Alcohol: **Y N** _____ drinks/week

Tobacco: **Y N** _____ pack/day

Caffeine: **Y N** _____ cups/day

28. Please list any other information you feel may be relevant to your situation or condition and would like to discuss with the doctor.

_____

_____

_____

_____

_____

_____

Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

Mercury

☐ Yes ☐ No Do you have amalgam (silver) fillings in your teeth? If so, How many? _____

☐ Yes ☐ No Have you ever had an amalgam removed? If Yes, How many_____ Date? _____

☐ Yes ☐ No If you had amalgams removed, was it done by a biological dentist using a safe protocol?

☐ Yes ☐ No Did your mother have amalgam when pregnant with you?

☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____

☐ Yes ☐ No Have you had any dental crowns? If yes, how many_____

☐ Yes ☐ No Have you had any bridges?

☐ Yes ☐ No Have you had any root canals?

☐ Yes ☐ No Have you had any tooth extractions?

☐ Yes ☐ No Do you have any dental implants, retainers or other metal in your mouth? Explain:_____

☐ Yes ☐ No Did you wear contact lenses during the 1980's or early 1990's?

☐ Yes ☐ No Did you take oral contraceptives during the 1980's or early 1990's?

☐ Yes ☐ No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?

☐ Yes ☐ No Have you noticed any adverse reactions to these shots?

☐ Yes ☐ No Do you have any tattoos with red ink?

☐ Yes ☐ No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

Lead

☐ Yes ☐ No Does your occupation involve soldering or metal salvage?

☐ Yes ☐ No Have you done any old home repair or sandblasting? If so, When_____

☐ Yes ☐ No Do you do a lot of painting?

☐	Yes	☐	No	Was your home built before 1978?
☐	Yes	☐	No	Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
☐	Yes	☐	No	Are you around a lot of fake leather, or vinyl?
☐	Yes	☐	No	Do you get stomach aches in the morning?

General Toxicity

☐	Yes	☐	No	Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
☐	Yes	☐	No	Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐	Yes	☐	No	Do you have your house sprayed with pesticides for pest control?
☐	Yes	☐	No	Do you spray herbicide (weed killers) in or around your home?
☐	Yes	☐	No	Do you use conventional insect repellants on your self or family?
☐	Yes	☐	No	Do you use conventional sunscreen?
☐	Yes	☐	No	Do you use conventional perfume or cologne every day?
☐	Yes	☐	No	Do you get your hair colored? If so, is it on the scalp?
☐	Yes	☐	No	Do you use aerosol hairspray?
☐	Yes	☐	No	Do you get your nails done? If so, how often? _____
☐	Yes	☐	No	Do you use air freshener in your house, work or car?
☐	Yes	☐	No	Do you drink filtered water? If so, what type of filter do you have?_____
☐	Yes	☐	No	Do you drink bottle water if so what kind?
☐	Yes	☐	No	Do you have a water filtration system for your entire house or shower filtration? If so, what type?_____
☐	Yes	☐	No	Does your spouse or other family members work around chemicals?
☐	Yes	☐	No	Can you think of any other toxic exposures you may have had?

Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in?_____ If so, what?_____

☐ Yes ☐ No Do you see mold growing at home, work or school?

☐ Yes ☐ No Have you ever had water damage at home, work or school?

☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?

☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?

☐ Yes ☐ No Does your basement ever get wet?

☐ Yes ☐ No Do you have a crawl space?

☐ Yes ☐ No Does your basement or crawl space have a sump pump?

☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

☐ Yes ☐ No Does your car have a mildew smell?

☐ Yes ☐ No Does anyone in your home have asthma like symptoms?

☐ Yes ☐ No Does anyone in your family have chronic sinus infections or irritations?

Lyme Disease

☐ Yes ☐ No Have you ever been diagnosed with Lyme Disease?

☐ Yes ☐ No Have you had dry sockets or infected tooth extractions?

☐ Yes ☐ No Do you have small joint pain?

☐ Yes ☐ No Have you ever been bitten by a tick or recluse spider?

☐ Yes ☐ No Have you ever seen a bulls-eye rash appear on any part of your body?

☐ Yes ☐ No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?

☐ Yes ☐ No Was your mother ever diagnosed with Lyme Disease?

☐ Yes ☐ No Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?

☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

Health History

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?

☐ Yes ☐ No Does anyone in your family experience similar symptoms to yours?

What is your birth order (i.e. first born, second, third, etc.)? _____.

☐ Yes ☐ No Do you have any history of kidney dysfunction?

☐ Yes ☐ No Do you or any immediate family member have a history with cancer?

☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?

☐ Yes ☐ No Are you currently having any thoughts of suicide?

☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?

☐ Yes ☐ No Do you have a history of strokes?

☐ Yes ☐ No Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?

☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?

☐ Yes ☐ No Are you in menopause?

Microbiome Health

☐ Yes ☐ No Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?

☐ Yes ☐ No Do you often have gas that has a sulfur or foul smell?

☐ Yes ☐ No Are you sensitive to supplements?

☐ Yes ☐ No Have you ever been vegan or vegetarian for any length of time?

☐ Yes ☐ No Can you tolerate Meat?

☐ Yes ☐ No Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?

☐ Yes ☐ No Have you taken birth control or Hormone replacement therapy for any length of time?

☐ Yes ☐ No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?

☐ Yes ☐ No Have been on antibiotics for any extended period of time or often as a child or adult?

☐ Yes ☐ No Were you caesarian delivered?

☐ Yes ☐ No Were you breast fed? If so, How long _____

☐ Yes ☐ No Does your gut temporarily feel better after a round of antibiotics?

How many times a day are you having a bowel movement? _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptom
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

	Column #1		Column #2
	Anxiety		Sensitivity to light
	Mood swings		Fatigue after exercising (feeling worse)
	Enraged behavior or anger for no reason		Bad night vision or seeing halos around lights
	Excessive shyness, timidity, social phobia (not typical to your personality)		Shortness of breath, with very little effort
	Irritability (not typical to your personality)		Excessive thirst and/or frequent urination
	Low body temperature (below 97.5°)		Red eyes or tearing
	Insomnia (can't get to sleep or return to sleep		Blurred vision at times
	Dizziness		Morning stiffness
	Sound in ears (ringing or hearing your heart beat)		Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Psychological symptoms, even thoughts of suicide		Chronic fatigue or weakness
	Sensitivity to sound		Non-restful sleep
	Indecisiveness		Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)

	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes)
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)

	Trouble processing new information
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry non-productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain-not necessarily true arthritis-can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities (hands and feet)

	Total Columns 1 & 2