Functional Medicine
Center of Fort Collins

CONFIDENTIAL PATIENT INFORMATION
(Please Print)

*****PLEASE REFRAIN FROM USING PERFUMES AND SCENTED LOTIONS*****

Full Name: _____ Date: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Social Security #: _____ Cell #:_____

Spouse/Guardian Name: _____

Marital Status: M S W D Age: _____ Birth Date: _____ Height: _____ Weight:_____ Pregnant?: _____ Number of Children:_____

Occupation: _____

Employer's Name and Address: _____

_____

Spouse Occupation/Employer: _____

Name of person responsible for account: _____

Do you have Medicare Coverage?: Yes _____ No _____

EmailAddress:_____

Would you like to be on our email list for our monthly newsletter? Yes _____ No _____

We will not release your email address to anyone outside the AK Center

WHO MAY WE THANK FOR REFERRING YOU? _____

I. HEALTH CONCERNS

List health concerns in order of importance:

	Rate Severity 1 = Mild 10 = Worst Imaginable	Date started, for how long?	If you had the condition before, when?	Did problem begin with an injury?	% of pain at present
1.					
2.					
3.					
4.					
5.					

What have you done for these conditions? Was it of benefit?

_____

_____

_____

Do you have a family history of this or any other symptoms (Please explain)

_____

_____

_____

Is this condition interfering with any of the following activities:

Work _____ Sleep _____ Daily Routine _____ Sports/Exercise _____ Other _____

What activities aggravate your condition:

_____

_____

_____

Please list Doctor's you have seen for this condition or general heatlh:

1. Name/Address: _____
   Type of Doctor: _____ Dates Seen: _____
   Diagnosis: _____ Treatment: _____
   Results: _____

2. Name/Address: _____
   Type of Doctor: _____ Dates Seen: _____
   Diagnosis: _____ Treatment: _____
   Results: _____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

Are you unable to do certain activities that you would like to do because of this pain, illness, condition? (i.e. sports, walk, pick up grandchildren, etc.) If so, what?

_____

_____

What lesson(s) have you taken home from your healing process to date:

_____

_____

Please list any surgeries you have had: (Please include all surgery)

1. Type: _____ Date: _____ Doctor: _____
2. Type: _____ Date: _____ Doctor: _____
3. Type: _____ Date: _____ Doctor: _____

Please list any accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

1. Type: _____ Date: _____Hospitalized: ____Yes_____No
2. Type: _____ Date: _____Hospitalized: ____Yes_____No
3. Type: _____ Date: _____Hospitalized: ____Yes_____No

Have you ever had x-rays taken: _____ Date(s): _____Where: _____
Area of Body: _____

Do you wear orthotics or heel lifts: Yes_____ No_____

II. CURRENT MEDICINE(S)

Please list ALL drugs you currently take or have taken in the past 6 months:

Name: _____ Dosage: _____ For what: _____
Name: _____ Dosage: _____ For what: _____
Name: _____ Dosage: _____ For what: _____
Name: _____ Dosage: _____ For what: _____
Name: _____ Dosage: _____ For what: _____

Please list all nutritional supplements, vitamins, and homeopathic remedies you presently take:

Name: _____ For what: _____
Name: _____ For what: _____
Name: _____ For what: _____
Name: _____ For what: _____
Name: _____ For what: _____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well being?

YES _____ NO _____ MAYBE _____

If dietary changes are indicated would you be willing to make changes in your diet?

YES _____ NO _____ MAYBE _____

Would you take whole food supplements if indicated?

YES _____ NO _____ MAYBE _____

Please mark any of the following conditions you have had or have now **(- have had +have now)**

☐ Allergy	☐ Diarrhea	☐ Measles	☐ Rheumatic Fever	☐ Alcoholism	☐ Eczema
☐ Miscarriage	☐ Stroke	☐ Anemia	☐ Multiple Sclerosis	☐ HIV (Aids)	☐ Gout
☐ Arteriosclerosis	☐ Emphysema	☐ Mumps	☐ Sinus Problems	☐ Arthritis	☐ Neuritis
☐ High Blood Pressure	☐ Asthma	☐ Nervousness	☐ Thyroid Problems	☐ Ulcers	☐ Cancer
☐ Heart Disease	☐ Depression	☐ Convulsions	☐ Venereal Disease	☐ Malaria	☐ Pleurisy
☐ Constipation	☐ Pneumonia	☐ Cold Sores	☐ Whooping Cough	☐ Food Allergies	☐ Neck Pain
☐ Gall Bladder Prob.	☐ Migraines	☐ Headaches	☐ Menstrual Cramps	☐ Back Pain	☐ Epilepsy
☐ Irregular Periods	☐ Diabetes	☐ Tuberculosis	☐ Heart Attack	☐ Low Blood Sugar	☐ Ringing in Ears

___Other (please explain) _____

_____

_____

Diet:

Please mark the selections below, which you currently include in your diet along with the frequency.

Alcohol		Eggs		Fasting		Artificial Sweetener	
Tobacco		Fruit		Diet Food		Weight Control	
Coffee		Beef		Refined Sugar		Raw Veg	
Soda		Poultry		Fish		Whole Grains	
Fried Foods		Dairy		Organic Foods		Seafood	
Canned Veg							

The type of diet I usually follow is classified as: _____

General Emotional Trauma:

With each of the following stress situations, please write either "P" for past or "C" for current:

	MILD	MODERATE	SEVERE
Childhood Stress			
School Stress			
Play or Recreational			
Family Stress			
Personal Relationship			
Stress of being Sick			

	MILD	MODERATE	SEVERE
Work Related Stress			
Stress of Commuting			
Loss of Loved One			
Change in Lifestyle			
Change in Vocation			
Abuse			

How do you grade your physical health?

Excellent ___ Good ___ Fair ___ Poor ___ Getting Better ___ Getting Worse ___

How do you grade your emotional/mental health?

Excellent ___ Good ___ Fair ___ Poor ___ Getting Better ___ Getting Worse ___

Is there anything, which has not been discussed, that may help us better understand you?

_____

_____

_____

_____

What do you hope to accomplish from our time together? _____

_____

_____

Print Patient Name_____ Date: _____

Signature _____