Soma Chiro & Functional Medicine
2345 Rice Street Suite 155
Roseville, MN 55113

Phone: 651-528-7978
Fax: 651-528-7941
Email: info@somachiromn.com

New Patient Intake Form

Personal Information

First Name ____________________ Last Name _________________________ Prefix _____
Email Address ________________ Phone Number: __________________ Cell/Home/Work
Street Address _________________________ City: __________ State: ___ Zip: _________
Date of Birth ____________ Gender _______ Legal Gender _______
Guardian (if minor) _______________________
Emergency Contact & Relationship _______________________________
Emergency Contact Number____________________
Family Doctor Name _______________________ Family Doctor Number _______________
Referred By ______________________________
Occupation _________________________ Employer _________________________
How Did You Hear About Us? ____________________________

Primary Language Spoken ________________________
Marital Status _______ Spouse Name __________________ Number of Children _______

Is This a Personal Injury/Worker's Comp Claim? Yes/No
If Yes, Who is the Responsible Party? ___________________________________
Do You Have Health Insurance? Yes/No
If Yes, What is Your Health Insurance Company? _________________________
Group Number/ID Number ____

Current Health Condition

Reason for visit:
____
____

When and how did your problem begin?
____
____

Have you received care for this problem? If yes, please explain.
____
____

What makes the problem better and/or worse?
____
____

Is the condition getting worse/ improving/ same? __________________________________
Is the condition intermittent (on and off)/ constant/ unsure? ______________________

Describe the pain: (circle all that applies)
Aching/Dull/Deep/Sharp/Burning/Throbbing/Numb/Tingling/Other

Does the pain travel to: (circle all the applies)
Shoulders/arms/fingers/legs/feet/toes/none

Rate your **current** pain level: (0=no pain, 10=emergency room pain)
0 1 2 3 4 5 6 7 8 9 10

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Rate your **average** pain level: (0=no pain, 10=emergency room pain)
0 1 2 3 4 5 6 7 8 9 10

For Women Only:
Are you currently pregnant or suspect you could be pregnant? Yes/No/Unsure
If yes, expected due date? __________________ Are you currently nursing? __________

Your Health Goals

Describe your health goals:
____
____

How would you rate your overall health currently? Poor/Fair/Good/Excellent/Unsure

Chiropractic History

What would you like to gain from chiropractic care?
Resolve existing condition ________ Overall wellness _________Both _________

Have you ever visited a chiropractor before? Yes/No

If yes, for what reason did you visit a chiropractor, what treatments were used, and what was the outcome of the treatments, and what did you like best/least about the treatments?
____
____
____

Personal and Family Health History

Indicate if YOU or any IMMEDIATE family members have any of the following conditions:

Rheumatoid Arthritis ____ Diabetes ____ Lupus ____ Heart Disease ____
High Blood Pressure ____ Stroke ____ Cancer ____ Migraines ____

If you selected yes to any of the previous conditions, please specify who has/had the condition:
____
____

For each of the conditions listed, please check/circle if YOU have had the condition in the past or currently:

Headaches ____ Neck Pain ____ Upper Back Pain ____ Mid Back Pain ____
Low Back Pain ____ Shoulder Pain ____ Arm Pain ____ Wrist Pain ____ Hand Pain ____ Upper Leg Pain ____
Hip Pain ____ Knee Pain ____ Ankle/Foot Pain ____ Jaw Pain ____ Joint Swelling ____ Arthritis ____
Rheumatoid Arthritis ____ General Fatigue ____ Vision Problems ____ Ringing in the Ears ____ Memory Problem ____ Broken Bones ____ Pacemaker ____ Dizziness ____ High Blood Pressure ____ Heart Attack/Disease ____ Chest Pain ____ Stroke ____ Angina ____ Kidney Stones ____ Kidney Disorders ____
Loss of Bladder Control ____ Painful Urination ____ Bladder Infection ____
Prostate Problems (men only) ____ Abnormal Weight Change ____ Loss of Appetite ____
Abdominal Pain ____ Ulcer ____ Hepatitis ____ Tumor ____ Gall Bladder Problems ____

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Sensitivity to Light ____ Cold Hands/Feet ____ Liver Disease ____ Thyroid Problems _____ Asthma ____ Sinus Problems ____ Diabetes ____ Excessive Thirst ____ Frequent Urination ____ Tobacco Use ____ Drug Dependence ____ Alcohol Dependence ____ Allergies ____ Depression ____ Anxiety ____ Lupus (SLE) ____ Epilepsy ____ Dermatitis/Eczema/Rash ____ Concussion ____ Hormonal Replacement ____ Birth Control Pills ____ Pregnancy ____ Cancer ____ Muscular Incoordination ____ Loss of Balance ____ Loss of Concentration ____ Anemia ____ Osteoporosis ____ Other _____

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries, accidents, or injuries? Yes/No
If yes, please explain:

____
____

Have you ever been hospitalized? Yes/No
If yes, please explain:

____
____

Have you had any notable childhood injuries? Yes/No
If yes, please explain:

____
____

Have you participated in youth or college sports? Yes/No
If yes, please explain:

____
____

Have you been involved in any car accidents? Yes/No
If yes, please explain and describe:

____
____

Lifestyle History

How much exercise do you perform:
1-2x/week ____ 3-5x/week ____ Daily ____ Seldom ____ Never ____

What types of exercises do you usually perform?

____
____

How do you normally sleep?
Back ____ Side ____ Stomach ____ Other ____

Do you usually wake up: (please check all the applies)
Refreshed ____ Tired ____ Stiff ____ Other ____

Do you commute to work? Yes/No
How many minutes per day do you commute to work? ______________________________
How many hours per day do you typically spend sitting (work included)? __________

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Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each of the following: (1=never, 5=high)

Alcohol: 1 2 3 4 5
Water: 1 2 3 4 5
Sugar: 1 2 3 4 5
Dairy: 1 2 3 4 5
Gluten: 1 2 3 4 5
Caffeine: 1 2 3 4 5
Processed Foods: 1 2 3 4 5
Sweeteners: 1 2 3 4 5
Sugary Drinks: 1 2 3 4 5
Tobacco: 1 2 3 4 5
Recreational Drugs: 1 2 3 4 5
Fast Food: 1 2 3 4 5

Please list any allergies:

____

____

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking and what you are taking them for?

____

____

____

____

Thoughts: Emotional Stress

Please rate your STRESS for each: (1=none, 5=high)

Home: 1 2 3 4 5
Work: 1 2 3 4 5
Life: 1 2 3 4 5
Financial: 1 2 3 4 5
Health: 1 2 3 4 5
Family: 1 2 3 4 5
Other: 1 2 3 4 5

Metabolic Assessment Form

Name: ______________________________ **Age:** _____ **Sex:** ____ **Date:** ____________

PART I

Please list the 5 major health concerns in your order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

PART II **Please circle the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
use laxatives frequently	0	1	2	3

Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids?	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	

Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

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Category IX

Symptom				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Symptom				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Symptom				
Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Symptom				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Symptom				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV

Symptom				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV

Symptom				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI

Symptom				
Are you perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 32 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII

Symptom				
How many years have you been menopausal?	________			
Since menopause, do you ever have uterine bleeding?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

PART III

How many alcohol beverages do you consume per week? ___________

How many caffeinated beverages do you consume per day? __________

How many times do you eat out per week? ___________

How many times a week do you eat raw nuts or seeds? _____________

How many times a week do you eat fish? ___________

How many times a week do you workout? ____________

List the three worst foods you eat during the average week: _____________________, ______________________, ______________________

List the three healthiest foods you eat during the average week: _____________________, _____________________, ___________________

Do you smoke?_______ If yes, how many times a day: ____________

Rate your stress levels on a scale of 1-10 during the average week: _________________

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____

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Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: ______________________________ Date: ______________

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Category	Symptom	Rating
Digestive Tract	Nausea, vomiting	⓪ ① ② ③ ④
	Diarrhea	⓪ ① ② ③ ④
	Constipation	⓪ ① ② ③ ④
	Bloated feeling	⓪ ① ② ③ ④
	Heartburn	⓪ ① ② ③ ④
	Intestinal, stomach pain	⓪ ① ② ③ ④
	Digestive Total:	
Joints / Muscles	Pain or aches in joints	⓪ ① ② ③ ④
	Arthritis, joint swelling	⓪ ① ② ③ ④
	Stiff or limitation of movement	⓪ ① ② ③ ④
	Pain or aches in muscles	⓪ ① ② ③ ④
	Feeling of weakness or tired	⓪ ① ② ③ ④
	Joints / Muscles Total:	
Emotional	Mood swings	⓪ ① ② ③ ④
	Anxiety, fear, nervousness	⓪ ① ② ③ ④
	Anger, irritability, aggression	⓪ ① ② ③ ④
	Depression	⓪ ① ② ③ ④
	Emotional Total:	
Weight / Food	Binge eating, drinking	⓪ ① ② ③ ④
	Craving certain foods	⓪ ① ② ③ ④
	Excessive weight	⓪ ① ② ③ ④
	Compulsive eating, food addictions	⓪ ① ② ③ ④
	Water retention	⓪ ① ② ③ ④
	Underweight	⓪ ① ② ③ ④
	Weight / Food Total:	
Energy / Sleep	Fatigue, sluggishness	⓪ ① ② ③ ④
	Apathy, lethargy	⓪ ① ② ③ ④
	Hyperactivity	⓪ ① ② ③ ④
	Restlessness, achiness	⓪ ① ② ③ ④
	Sleep disturbances	⓪ ① ② ③ ④
	Energy / Sleep Total:	
Skin	Acne	⓪ ① ② ③ ④
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④
	Hair loss	⓪ ① ② ③ ④
	Flushing, hot flashes	⓪ ① ② ③ ④
	Excessive sweating	⓪ ① ② ③ ④
	Skin Total:	
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④
	Rapid or pounding heartbeat	⓪ ① ② ③ ④
	Chest pain	⓪ ① ② ③ ④
	Heart Total:	
Other	Frequent illness	⓪ ① ② ③ ④
	Frequent or urgent urination	⓪ ① ② ③ ④
	Genital itch or discharge	⓪ ① ② ③ ④
	Other Total:	
Respiratory	Chest congestion	⓪ ① ② ③ ④
	Asthma, bronchitis	⓪ ① ② ③ ④
	Shortness of breath	⓪ ① ② ③ ④
	Difficulty breathing	⓪ ① ② ③ ④
	Respiratory Total:	
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④
	Bags or dark circles under eyes	⓪ ① ② ③ ④
	Blurred or restricted vision	⓪ ① ② ③ ④
	Eyes Total:	
Nose	Stuffy nose	⓪ ① ② ③ ④
	Sinus problems or dripping nose	⓪ ① ② ③ ④
	Hay fever	⓪ ① ② ③ ④
	Sneezing attacks	⓪ ① ② ③ ④
	Excessive mucus	⓪ ① ② ③ ④
	Nose Total:	
Mouth / Throat	Frequent, consistent coughing	⓪ ① ② ③ ④
	Gagging, need to clear throat	⓪ ① ② ③ ④
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
	Canker sores, other mouth sores	⓪ ① ② ③ ④
	Mouth / Throat Total:	
Ears	Itchy ears	⓪ ① ② ③ ④
	Earaches, ear infections	⓪ ① ② ③ ④
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④
	Ringing in ears, hearing loss	⓪ ① ② ③ ④
	Ears Total:	
Head	Headaches	⓪ ① ② ③ ④
	Faintness or lightheadedness	⓪ ① ② ③ ④
	Dizziness	⓪ ① ② ③ ④
	Head Total:	
Cognitive	Poor memory, recall	⓪ ① ② ③ ④
	Confusion, poor comprehension	⓪ ① ② ③ ④
	Poor concentration	⓪ ① ② ③ ④
	Poor physical coordination	⓪ ① ② ③ ④
	Difficulty in making decisions	⓪ ① ② ③ ④
	Stuttering, stammering	⓪ ① ② ③ ④
	Slurred speech	⓪ ① ② ③ ④
	Learning disabilities	⓪ ① ② ③ ④
	Cognitive Total:	

Grand Total __________

For Practitioner Use Only:

Urinary pH____________

Metagenics®

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
◯ Yes (1 pt.) ◯ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
◯ Cimetidine (2 pts.) ◯ Acetaminophen (2 pts.) ◯ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
◯ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
◯ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently (within the last 6 months) or have you regularly used tobacco products?
◯ Yes (2 pts.) ◯ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
◯ Yes (1 pt.) ◯ No (0 pt.)

7. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

10. Do you have a personal history of:
◯ Environmental and/or chemical sensitivities (5 pts.)
◯ Chronic fatigue syndrome (5 pts.)
◯ Multiple chemical sensitivity (5 pts.)
◯ Fibromyalgia (3 pts.)
◯ Parkinson's type symptoms (3 pts.)
◯ Alcohol or chemical dependence (2 pts.)
◯ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
◯ Yes (1 pt.) ◯ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

Total __________

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
◯ Yes (1 pt.) ◯ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
◯ Yes (1 pt.) ◯ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
◯ Yes (1 pt.) ◯ No (0 pt.)

Total __________

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total __________ (High ›50; moderate 15-49; low ‹14)
Part 2: XTT Total __________ (High ›10; moderate 5-9; low ‹4)
Part 3: Alkalizing Assessment Total __________ (High ≥1)
Urinary pH __________

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

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Identi-T™ Stress Assessment

Name ______________________ **Age** __________ **Sex** __________ **Date**__________

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: __________

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: __________

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: __________

Section D:

1. Have trouble organizing my thoughts 0 1 2 3
2. Get easily distracted and lose focus 0 1 2 3
3. Have difficulty making decisions and mistrust my judgment 0 1 2 3
4. Feel depressed and apathetic 0 1 2 3
5. Lack the motivation and energy to stay on task and pay attention 0 1 2 3
6. Am forgetful 0 1 2 3
7. Feel unsettled, restless, and anxious 0 1 2 3
8. Wake up tired and unrefreshed 0 1 2 3
9. Experience heartburn and indigestion 0 1 2 3
10. Catch colds or infections easily 0 1 2 3

Total points: ___________

Section E:

1. Feel tired for no apparent reason 0 1 2 3
2. Experience lingering mild fatigue after exertion or physical activity 0 1 2 3
3. Find it difficult to concentrate and complete tasks 0 1 2 3
4. Feel depressed and apathetic 0 1 2 3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason 0 1 2 3
6. Have little or no interest in sex 0 1 2 3
7. Sweat spontaneously during the day 0 1 2 3
8. Feel puffy and retain fluids 0 1 2 3
9. Sleep more than nine hours a night 0 1 2 3
10. Have poor muscle tone 0 1 2 3
11. Have trouble losing weight 0 1 2 3
12. Wake up tired even though I seem to get plenty of sleep 0 1 2 3
13. Have no energy and feel physically weak 0 1 2 3
14. Am susceptible to colds and the flu 0 1 2 3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches 0 1 2 3

Total points: ___________

Add points from sections A, B & C	**Total for A, B & C:** ___________
Add points from sections C, D & E	**Total for C, D & E:** ___________

LIfestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   ____
3. I eat breakfast _________ times a week. My typical breakfast is: ___________________________
4. I take a multiple vitamin/mineral ___________ days per week. I take a fish oil supplement _____________ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke ________ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

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<u>Functional Medicine Informed Consent</u>

About Functional Medicine
Functional Medicine is concerned with identifying the underlying factors that may be contributing to your health issues. Once identified these factors may be addressed with, but are not limited to, diet and nutritional supplementation, chiropractic, acupuncture, meditation, lifestyle recommendations, stress management, biofeedback and neurofeedback, habit change and homeopathic stimulation of natural healing.

Regarding Treatment and Care
I hereby request nutritional consultations and functional medicine treatment. I understand that in the practice of functional medicine the conventional medical community considers some treatments "alternative" and that there are some risks to treatment. I do not expect the Doctor to be able to anticipate and explain *all* the risks and complications and I wish to rely on the Doctor to exercise judgment during the course of treatment based upon the facts then known and in my best interest.

Regarding Diet Recommendations and Nutritional/Herbal Supplements
We may make diet recommendations and recommendations regarding use of nutritional and herbal supplements in order to supply nutrition to support the physiological and biomechanical processes of the human body. Although these foods and products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

As a service to you, we make nutritional supplements available in our office. We purchase only top quality products and only from manufacturers who have gained our confidence through considerable research and experience. You are under no obligation to purchase these in our office but we cannot guarantee a similar quality from an outside source. Refunds will be given to any supplement that is unopened and returned within 14 days of purchase.

Regarding Privacy Practices and E-mail Correspondence
The Health Insurance Portability and Accountability Act (HIPAA) requires us to let you know how your Patient Health Information (PHI) is going to be used and your rights concerning those records. I agree to allow this office to use my PHI for the purpose of treatment and coordination of care. I have the right to examine and obtain a copy of my health records and request corrections. I can request to know what disclosures have been made and submit any future restrictions. All staff will take precautions to assure my records are not available to those who do not need them. I also authorize correspondence deemed appropriate by the doctor to be sent to me by e-mail.

I have read and understand the **Treatment and Care Consent,** the **Diet Recommendations and Nutritional/ Herbal Supplements Consent,** and the **Privacy Practices and E-mail Correspondence.**

X____ Signature __________________________ **Date**