

**FUNCTIONAL MEDICINE
 PATIENT INFORMATION**

NEW PATIENT
 REACTIVATE (1 YR)

Please fill out this form as completely as possible. In order for us to provide the very best care, it is important that we get a complete picture of your overall health.

Legal Name (First, Middle, Last):		Today's Date:
Street Address:		Home Phone: <input type="checkbox"/> Preferred
City / State / Zip:		Work Phone: <input type="checkbox"/> Preferred
Social Security #:	Birthdate:	Cell Phone: <input type="checkbox"/> Preferred
Driver's license #:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Cell Carrier: (for text reminders)
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic		Email:
Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other: _____		
Occupation:		Employer:
Primary Medical Doctor:		Medical Doctor Clinic & City:
Emergency Contact:		Emergency Contact's Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Spouse's Name:	
Spouse's Phone:	Spouse's Employer:	
How Did You Hear About Us? (Check all that apply) <input type="checkbox"/> I have been a past patient <input type="checkbox"/> Referred by (name): _____ <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> TV <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Sign/Location <input type="checkbox"/> Other: _____		

REASON FOR VISIT

What is the primary reason you've come for a consultation? Please provide details including: when & why the problem started, what has been done to date, the results you've had, whether the condition is improving, worsening, or staying the same.

Are you experiencing any secondary health conditions? No If yes, please describe.

List current prescriptions, over-the-counter medications, and supplements: None

Name	Dosage (mg, mL, ...)	Form (Tablets, Caps...)	How Often (times per day, wk, mo)	Duration		
				Chronic	As Needed	Unknown
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			
			x's per			

List allergies None

Drugs, Medications (ADR):	Foods:
Environmental:	Other: (latex, animals...)

MEDICAL HISTORY

List major illnesses, injuries, falls, hospitalizations, accidents, or surgeries: None

Date	Condition(s)	Treating Doctor	Results
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications
			<input type="checkbox"/> Full Recovery <input type="checkbox"/> Complications

Are you currently seeing any other healthcare professionals such as a dentist, massage therapist, acupuncturist, psychologist, etc? If so, please explain.

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know.

Please review this form to be sure your answers are accurate, and then sign below.

 Patient Name (printed)
 X

 Patient Signature

 Date
 X

 Parent/Guardian/Legal Representative Signature