

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) _____

How did you hear about our practice?

Clinic website IFM website Referral from doctor Referral from friend/family member
 Social media Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Severity			Prior Treatment/Approach	Success	Success		
		Mild	Moderate	Severe			Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X			<i>Elimination Diet</i>		X		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you feel rested upon awakening? Yes No

Do you use sleeping aids? Yes No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? Yes A little No

Are there any problems that limit exercise? Yes No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? Yes No

If yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein
 Blood Type Low sodium No Dairy No Wheat Gluten Free
 Other: _____

Do you have sensitivities to certain foods? Yes No

If yes, list food and symptoms: _____

Do you have an aversion to certain foods? Yes No

If yes, explain: _____

Do you adversely react to: *(Check all that apply)*

- Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese Citrus foods
 Chocolate Alcohol Red wine Sulfite-containing foods (wine, dried fruit, salad bars)
 Preservatives Food colorings Other food substances: _____

Are there any foods that you crave or binge on? Yes No

If yes, what foods? _____

Do you eat 3 meals a day? Yes No If no, how many _____

Does skipping a meal greatly affect you? Yes No

How many meals do you eat out per week? 0–1 1–3 3–5 >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Late-night eating | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Dislike healthy foods | <input type="checkbox"/> Have negative relationship to food |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.) |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Healthy foods not readily available | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> Confused about nutrition advice |

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? Yes No If yes, check amounts:

Coffee (cups per day) 1 2-4 >4 Tea (cups per day) 1 2-4 >4

Caffeinated sodas—regular or diet (cans per day) 1 2-4 >4

Do you have adverse reactions to caffeine? Yes No

If yes, explain: _____

When you drink caffeine do you feel: Irritable or wired Aches or pains

Smoking

Do you smoke currently? Yes No Packs per day: _____ Number of years _____

What type? Cigarettes Smokeless Pipe Cigar E-Cig

Have you attempted to quit? Yes No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? Yes No

Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

1-3 4-6 7-10 >10 None

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever had a problem with alcohol? Yes No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? Yes No

Other Substances

Are you currently using any recreational drugs? Yes No

If yes, type: _____

Have you ever used IV or inhaled recreational drugs? Yes No

Stress

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you use relaxation techniques? Yes No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

Meditation Breathing Tai Chi Yoga Prayer Other: _____

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes No

What are your hobbies or leisure activities? _____

Relationships

Marital status: Single Married Divorced Gay/Lesbian Long-Term Partner Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? Yes No *(Check all that apply)*

Spouse/Partner Family Friends Religious/Spiritual Pets Other: _____

Do you have a religious or spiritual practice? Yes No

If yes, what kind? _____

How well have things been going for you? *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly			Fine			Very Well			
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Were there any pregnancy or birth complications? Yes No

If yes, explain: _____

You were: Breast-fed/How long? _____ Bottle-fed/Type of formula: _____ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? Yes No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

Did you eat a lot of sugar or candy as a child? Yes No

Dental History:

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings _____ Gold fillings _____ Root canals _____ Implants _____

Caps/Crowns _____ Tooth pain _____ Bleeding gums _____ Gingivitis _____

Problems with chewing _____ Other dental concerns (explain): _____

Have you had any mercury fillings removed? Yes No If yes, when: _____

How many fillings did you have as a kid? _____

Do you brush regularly? Yes No Do you floss regularly? Yes No

Environmental/Detoxification History

Do any of these significantly affect you?

Cigarette smoke Perfume/colognes Auto exhaust fumes Other: _____

In your work or home environment are you regularly exposed to: (Check all that apply)

Mold Water leaks Renovations Chemicals Electromagnetic radiation

Damp environments Carpets or rugs Old paint Stagnant or stuffy air Smokers

Pesticides Herbicides Harsh chemicals (solvents, glues, gas, acids, etc) Cleaning chemicals

Heavy metals (lead, mercury, etc.) Paints Airplane travel Other _____

Have you had a significant exposure to any harmful chemicals? Yes No

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? Yes No

If yes, do they live: Inside Outside Both inside and outside

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? Yes No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? Yes No Tylenol (acetaminophen)? Yes No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? Yes No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

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 | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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 makes 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? _____
