

Functional Medicine & Cellular Health Intake Form

A streamlined, root-cause intake designed to identify key terrain, symptom, lifestyle, and lab patterns for phased wellness planning.

Client Name: -----	Date of Birth: -----
Primary Goal: -----	Best Email / Phone: -----

How to complete this form: Please answer as clearly as you can. This form is used for wellness coaching, education, and root-cause review. It does not diagnose, treat, or replace medical care.

1. What brings you here?

Keep this section brief and focused on your top priorities.

Top health concerns:

How long have these concerns been present?

What are you hoping to improve in the next 3–6 months?

2. Core symptom snapshot

Rate each area from 0–3. 0 = none, 1 = mild, 2 = moderate, 3 = significant.

Area	0	1	2	3	Notes / examples
Energy / fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Area	0	1	2	3	Notes / examples
Sleep / recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brain fog / focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Digestion / bloating / stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Inflammation / pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress / anxiety / overwhelm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hormones / weight / cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immune / allergies / infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Personal and medical background

Current diagnoses / major health history:

Surgeries / hospitalizations / major injuries:

Family history patterns that matter (thyroid, diabetes, heart disease, autoimmunity, cancer, dementia, addiction, etc.):

4. Current medications, supplements, and therapies

Medication / Supplement / Therapy	Dose	How Often	Reason / Goal

Medication / Supplement / Therapy	Dose	How Often	Reason / Goal

- Hormone therapy
- IV nutrient therapy
- PEMF / miHealth
- Hyperbaric oxygen
- Bioenergetic scans
- Peptides / biologics
- Red light / NIR
- Sauna / ozone sauna
- Acupuncture / bodywork
- Other modality

5. Diet, digestion, and hydration

Describe a typical day of eating (breakfast, lunch, dinner, snacks):

- Constipation
- Bloating
- Gas / burping
- Sugar cravings
- Loose stools
- Reflux
- Food sensitivities
- Salt cravings

How much water do you drink daily? Do you use minerals / electrolytes / salt?

6. Sleep, stress, and lifestyle terrain

- Trouble falling asleep
- Wake unrefreshed
- High stress load
- Low exercise tolerance
- Trouble staying asleep
- Need caffeine to function
- Poor stress recovery
- Overtraining history

What are your main current stressors?

What helps you feel calm, grounded, or restored?

7. Environment, exposures, and hidden burden

- Mold / water damage
- Past heavy antibiotic use
- EBV / mono history
- Dental infections / root canals
- Pesticide / solvent exposure
- Poor tolerance to detox support
- Chemical sensitivity
- Tick bite / Lyme concern
- Long COVID / post-viral symptoms
- Amalgam fillings
- Medication sensitivity
- Histamine / MCAS-type reactions

Please describe any known mold, toxin, viral, or environmental concerns:

8. Hormones, metabolism, and cellular terrain

- Weight gain / hard to lose weight
- Low libido
- Cold intolerance
- Cycle issues / heavy bleeding / PMS
- Fluid retention
- Belly fat / insulin resistance concern
- Hair thinning / hair loss
- Hot flashes / night sweats
- Symptoms of low testosterone
- Frequent hunger / blood sugar swings

What patterns do you suspect may be driving your symptoms (gut, hormones, mold, inflammation, nervous system, etc.)?

9. Labs, reports, and records available

- CBC / CMP
- Iron / ferritin
- Lipids / glucose / insulin / A1c
- Stool / gut testing
- Mycotoxin testing
- Genetics / SNPs
- Imaging / MRI / CT / ultrasound
- Thyroid panel
- Vitamin D / B12 / folate
- Hormone panel
- Organic acids / micronutrients
- DUTCH / neurotransmitters
- E4L / bioenergetic scans

List any major abnormal findings you already know about:

10. Planning priorities and readiness

- Phase 1: calm inflammation / stabilize
- Phase 1: gut support
- Phase 1: drainage / detox support
- Phase 1: pain / recovery
- Phase 1: energy / mitochondria
- Phase 1: sleep / nervous system
- Phase 1: hormones / metabolism

What is realistic for you right now in terms of time, and follow-through?

Readiness item	1	2	3	4	5
Ready to make food changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ready to take supplements consistently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ready to prioritize sleep/stress work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desire for accountability / support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Final questions

What do you most want me to understand about your health journey?

What has been the hardest part of all of this?

What gives you hope right now?

12. Signature and acknowledgment

I understand this intake form is used for wellness coaching, education, and root-cause-oriented health review. *It does not diagnose, treat, or replace medical care.* I affirm the information I provided is accurate to the best of my knowledge.

Client Signature: _____ Date: _____

Office Use Only | Root-Cause / Terrain Review

Review Area	Notes