Comprehensive Functional Medicine & Cellular Health Intake Form

A thorough root-cause and terrain-focused intake designed to capture health history, cellular stressors, lifestyle patterns, symptoms, environmental exposures, readiness, and priorities for individualized wellness planning. This intake must be submitted with the separate Medication & Supplement List form.

Full legal name:

Preferred name:

Date of birth:

Age: **Phone:**

Email:

Address:

Occupation:

Emergency contact:

Relationship / phone:

Primary health goals for the next 3-6 months:

Top 3-5 symptoms or concerns, in order of priority:

Reminder:

Please complete and submit the separate Medication & Supplement List with this intake, including prescriptions, over-the-counter medications, hormones, peptides, supplements, herbs, injections, IV therapies, and frequency of use.

Health Goals, Timeline & Current Care Team

What brings you here now? Please describe what changed, worsened, or prompted you to seek support:

How long have these concerns been present? Include approximate onset, triggers, or major life/health events around that time:

What have you already tried? What helped, what did not help, and what made symptoms worse?

Current care team and providers:

Primary care:

Specialists:

Therapists / coaches:

- ☐ I am currently under medical care for an active condition
- ☐ I have recent labs available
- ☐ I have recent imaging available
- ☐ I have functional testing available
- ☐ I need help organizing records
- ☐ I am seeking education/coaching support only

Medical History

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke / TIA
- ☐ Diabetes
- ☐ High cholesterol / ApoB concerns
- ☐ Autoimmune condition
- ☐ Asthma / COPD
- ☐ Chronic fatigue syndrome
- ☐ Migraines / headaches
- ☐ Neuropathy
- ☐ Anxiety
- ☐ ADHD / focus concerns
- ☐ IBS / IBD
- ☐ Gallbladder disease
- ☐ Kidney disease
- ☐ EBV / mono history
- ☐ Lyme / tick-borne illness concern
- ☐ MCAS / histamine intolerance
- ☐ Low blood pressure
- ☐ Palpitations / arrhythmia
- ☐ Blood clot history
- ☐ Insulin resistance / prediabetes
- ☐ Thyroid disorder
- ☐ Cancer history
- ☐ Sleep apnea
- ☐ Fibromyalgia
- ☐ Seizures
- ☐ Dizziness / vertigo
- ☐ Depression
- ☐ Eating disorder history
- ☐ GERD / reflux
- ☐ Liver disease
- ☐ Recurrent infections
- ☐ Long COVID / post-viral symptoms
- ☐ Mold illness / CIRS concern
- ☐ POTS / dysautonomia

Please describe current diagnoses, major health history, and approximate dates:

Surgical, Hospitalization, Injury & Procedure History

Past surgeries or procedures. Include date/year, reason, outcome, complications, implants, mesh, hardware, etc.:

Hospitalizations, ER visits, major illnesses, severe infections, or complications:

Major injuries, concussions, falls, fractures, motor vehicle accidents, sports injuries, or chronic pain triggers:

- ☐ Appendix removed
- ☐ Gallbladder removed
- ☐ C-section
- ☐ Spine/neck/back procedure
- ☐ Dental surgery
- ☐ Tonsils/adenoids removed
- ☐ Hysterectomy
- ☐ Joint surgery
- ☐ Cosmetic surgery
- ☐ Implants or medical hardware

Additional notes about healing, scarring, anesthesia, bleeding, clotting, or recovery:

Childhood Illnesses, Birth History & Early-Life Terrain

- ☐ C-section birth
- ☐ NICU stay
- ☐ Breastfed
- ☐ Frequent ear infections
- ☐ Frequent antibiotics
- ☐ Asthma
- ☐ Allergies
- ☐ Digestive problems
- ☐ Mononucleosis / EBV
- ☐ Measles/mumps history
- ☐ Concussions/head injuries
- ☐ ADHD symptoms
- ☐ Trauma/adverse childhood stress
- ☐ Premature birth
- ☐ Formula-fed
- ☐ Colic
- ☐ Frequent strep infections
- ☐ Tonsils/adenoids removed
- ☐ Eczema
- ☐ Chronic constipation
- ☐ Recurrent infections
- ☐ Chickenpox
- ☐ High fevers
- ☐ Learning difficulties
- ☐ Anxiety as a child
- ☐ Significant grief or family stress

Describe childhood illnesses, early antibiotic exposure, digestive issues, allergies, trauma, or important early health patterns:

Family health patterns: thyroid, diabetes, heart disease, cancer, autoimmune disease, dementia, addiction, mood disorders, inf

Allergies, Sensitivities & Adverse Reactions

- ☐ Medication allergy
- ☐ Food allergy
- ☐ Food sensitivity
- ☐ Gluten sensitivity
- ☐ Dairy sensitivity
- ☐ Egg sensitivity
- ☐ Nut sensitivity
- ☐ Shellfish/fish sensitivity
- ☐ Soy sensitivity
- ☐ Corn sensitivity
- ☐ Histamine reactions
- ☐ MCAS-type reactions
- ☐ Chemical sensitivity
- ☐ Fragrance sensitivity
- ☐ Mold sensitivity
- ☐ Pollen/environmental allergies
- ☐ Latex allergy
- ☐ Contrast dye reaction
- ☐ Anesthesia reaction
- ☐ Supplement reaction
- ☐ Herbal reaction
- ☐ Poor detox tolerance
- ☐ Sensitive to caffeine
- ☐ Sensitive to alcohol
- ☐ Sensitive to medications generally
- ☐ Unknown reactions that need clarification

List all known allergies/sensitivities and describe the reaction: rash, hives, swelling, breathing issues, GI upset, anxiety, insom

Foods or substances you currently avoid and why:

Current Medications, Supplements & Therapies - Separate Sheet Requi

Important:

This intake does not replace the Medication & Supplement List. Please complete the separate sheet in full and include medication name, dose, frequency, start date, reason, prescribing provider, supplement brand, and any reactions.

- ☐ I completed the separate Medication & Supplement List
- ☐ I take prescription medications
- ☐ I take OTC medications
- ☐ I take supplements/herbs
- ☐ I use hormone therapy
- ☐ I use peptides or biologics
- ☐ I receive IV nutrient therapy
- ☐ I receive injections
- ☐ I use red light / NIR therapy
- ☐ I use PEMF / frequency medicine
- ☐ I use sauna / ozone sauna
- ☐ I use hyperbaric oxygen
- ☐ I use chiropractic / bodywork
- ☐ I use acupuncture
- ☐ I use E4L / bioenergetic scans
- ☐ I have had adverse reactions to supplements or therapies

Any medication/supplement/therapy concerns you want reviewed first:

Any recent medication changes, dose changes, discontinued medications, or side effects:

Comprehensive Symptom Review - Rate Severity

Use 0 = none, 1 = mild, 2 = moderate, 3 = severe. Add notes for timing, triggers, or patterns.

Symptom Area	0	1	2	3	Notes / examples
Energy / fatigue	☐	☐	☐	☐	
Brain fog / focus	☐	☐	☐	☐	
Memory / cognition	☐	☐	☐	☐	
Mood / anxiety	☐	☐	☐	☐	
Sleep / recovery	☐	☐	☐	☐	
Headaches / migraines	☐	☐	☐	☐	
Dizziness / balance	☐	☐	☐	☐	
Pain / inflammation	☐	☐	☐	☐	
Joint stiffness	☐	☐	☐	☐	
Muscle weakness	☐	☐	☐	☐	
Exercise intolerance	☐	☐	☐	☐	
Shortness of breath	☐	☐	☐	☐	
Heart palpitations	☐	☐	☐	☐	
Blood sugar crashes	☐	☐	☐	☐	
Cravings / appetite	☐	☐	☐	☐	
Weight gain/loss resistance	☐	☐	☐	☐	
Cold hands/feet	☐	☐	☐	☐	
Temperature intolerance	☐	☐	☐	☐	
Skin / rashes	☐	☐	☐	☐	
Hair thinning/loss	☐	☐	☐	☐	
Immune / infections	☐	☐	☐	☐	
Allergies / sinus	☐	☐	☐	☐	
Urinary symptoms	☐	☐	☐	☐	
Sexual health/libido	☐	☐	☐	☐	

Sleep Schedule, Recovery & Circadian Rhythm

Usual bedtime: _____ **Usual wake time:** _____

Hours of sleep/night: _____ **Sleep quality 1-10:** _____

How long to fall asleep: _____ **Times waking/night:** _____

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Wake unrefreshed
- ☐ Wake between 2-4 AM
- ☐ Snoring
- ☐ Possible sleep apnea
- ☐ Restless legs
- ☐ Night sweats
- ☐ Vivid dreams/nightmares
- ☐ Use sleep medication
- ☐ Use magnesium/glycine/melatonin/etc.
- ☐ Use screens within 1 hour of bed
- ☐ Caffeine after noon
- ☐ Need caffeine to function
- ☐ Shift work or irregular schedule
- ☐ Morning sunlight exposure

Describe your sleep routine, nighttime symptoms, morning energy, and what improves or worsens sleep:

Nutrition, Food Pattern & Hydration

Meals per day: **Snacks per day:**

Protein per day if known: **Water intake/day:**

Electrolytes/minerals/salt:

Caffeine amount/timing:

Alcohol amount/frequency:

Typical breakfast:

Typical lunch:

Typical dinner:

Typical snacks, drinks, desserts, cravings, or nighttime eating:

- ☐ High protein diet
- ☐ Low carb / keto
- ☐ Dairy-free
- ☐ Intermittent fasting
- ☐ Processed foods often
- ☐ Salt cravings
- ☐ Binge/restrict pattern
- ☐ Carnivore / animal-based
- ☐ Gluten-free
- ☐ Vegetarian/vegan
- ☐ Frequent restaurant meals
- ☐ Sugar cravings
- ☐ Poor appetite
- ☐ Food fear or avoidance

Nutrition Continued - Food Reactions, Appetite & Hydration

What foods make you feel better or worse? Include known triggers and foods you tolerate well:

Describe appetite, cravings, meal timing, fasting pattern, nighttime eating, or blood sugar crashes:

Describe hydration habits: water, minerals/electrolytes, thirst, urination, dry mouth, headaches, or dizziness:

Any dietary restrictions, beliefs, budget concerns, cooking limitations, or support needed for food planning:

Digestion, Gut Health & Elimination

Bowel movements/day or/wee **ol stool type if known:**

- ☐ Constipation
- ☐ Alternating stool pattern
- ☐ Gas
- ☐ Reflux/heartburn
- ☐ Abdominal pain
- ☐ Mucus in stool
- ☐ Hemorrhoids
- ☐ Low bile symptoms
- ☐ Candida history
- ☐ SIBO concern
- ☐ Frequent antibiotics
- ☐ Loose stools
- ☐ Bloating
- ☐ Burping
- ☐ Nausea
- ☐ Undigested food
- ☐ Blood in stool
- ☐ Gallbladder removed
- ☐ Food sensitivities
- ☐ Parasite concern
- ☐ H. pylori history
- ☐ Poor tolerance to probiotics

Describe digestion from mouth to elimination, including timing, triggers, stool quality, and food reactions:

Prior gut testing, colonoscopy/endoscopy, stool tests, diagnoses, or treatments:

Activity, Movement, Exercise & Recovery

Current activity level:

Steps/day if known: **ercise type/frequency:**

- ☐ Sedentary most days
- ☐ Walking regularly
- ☐ Strength training
- ☐ Cardio training
- ☐ Yoga/Pilates/stretching
- ☐ HIIT
- ☐ Physically demanding job
- ☐ Overtraining history
- ☐ Exercise intolerance
- ☐ Post-exertional crash
- ☐ Shortness of breath with exertion
- ☐ Pain limits activity
- ☐ Joint instability
- ☐ Poor recovery
- ☐ Dizziness with activity
- ☐ Low motivation
- ☐ Muscle cramps
- ☐ Injury rehab needed

Describe your current exercise routine, limitations, pain patterns, recovery, and goals:

What movement feels safe, energizing, or doable right now?

Stress, Nervous System, Emotional Terrain & Resilience

- ☐ High daily stress
- ☐ Work stress
- ☐ Financial stress
- ☐ Trauma history
- ☐ Anxiety
- ☐ Irritability
- ☐ Hypervigilance
- ☐ Poor stress recovery
- ☐ Difficulty relaxing
- ☐ People-pleasing/poor boundaries
- ☐ Caregiver stress
- ☐ Relationship stress
- ☐ Grief/loss
- ☐ Panic attacks
- ☐ Depression
- ☐ Emotional numbness
- ☐ Burnout
- ☐ Low resilience
- ☐ Racing thoughts
- ☐ Spiritual distress

What are your main current stressors?

What helps regulate your nervous system: prayer, breathwork, sunlight, walking, grounding, journaling, bodywork, music, etc.

Anything you want me to understand about trauma, grief, emotional safety, or support needs:

Hormones, Metabolism & Reproductive Health

- ☐ Weight gain
- ☐ Difficulty losing weight
- ☐ Frequent hunger
- ☐ Erectile dysfunction
- ☐ PMS
- ☐ Irregular cycles
- ☐ PCOS concern
- ☐ Infertility history
- ☐ Perimenopause
- ☐ Hot flashes
- ☐ Hair thinning
- ☐ Cold intolerance
- ☐ Thyroid symptoms
- ☐ Belly fat / insulin resistance concern
- ☐ Blood sugar swings
- ☐ Low libido
- ☐ Low testosterone symptoms
- ☐ Heavy bleeding
- ☐ Painful periods
- ☐ Fibroids/cysts
- ☐ Pregnancy/postpartum concerns
- ☐ Menopause
- ☐ Night sweats
- ☐ Acne
- ☐ Fluid retention
- ☐ Adrenal stress symptoms

Describe menstrual history, menopause status, pregnancies, hormone therapy, libido, weight/metabolic patterns, and thyroid/a

For women: date of last menstrual period, cycle length, bleeding pattern, PMS symptoms, contraceptive/hormone use. For men

Environmental Exposures, Immune Burden & Detox Tolerance

- ☐ Mold/water-damaged building
- ☐ Chemical exposure
- ☐ Pesticide/herbicide exposure
- ☐ Heavy metal concern
- ☐ Root canals
- ☐ Tick bite
- ☐ EBV/mono history
- ☐ Long COVID/post-viral symptoms
- ☐ Histamine/MCAS reactions
- ☐ Poor detox tolerance
- ☐ Alcohol intolerance
- ☐ EMF sensitivity concern
- ☐ Well water exposure
- ☐ Musty home/workplace
- ☐ Fragrance sensitivity
- ☐ Solvent/paint exposure
- ☐ Amalgam fillings
- ☐ Dental infections
- ☐ Lyme concern
- ☐ Frequent viral infections
- ☐ Recurrent sinus infections
- ☐ Medication sensitivity
- ☐ Sauna intolerance
- ☐ Caffeine sensitivity
- ☐ Occupational exposure
- ☐ Pet exposure concerns

Describe known or suspected mold, toxin, dental, viral, immune, tick, chemical, or environmental concerns:

How do you respond to detox support, sauna, fasting, supplements, binders, glutathione, exercise, or stress?

Labs, Imaging, Records & Functional Testing

- ☐ CBC/CMP
- ☐ Thyroid panel
- ☐ Fasting insulin/glucose/A1c
- ☐ Hormone panel
- ☐ Inflammatory markers
- ☐ Stool/gut testing
- ☐ Micronutrients
- ☐ Heavy metals
- ☐ Neurotransmitters
- ☐ Food sensitivity testing
- ☐ Cardiac testing
- ☐ E4L/bioenergetic scans
- ☐ Iron/ferritin/TIBC
- ☐ Vitamin D/B12/folate
- ☐ Lipid panel/ApoB
- ☐ Cortisol/DHEA
- ☐ Autoimmune markers
- ☐ Organic acids test
- ☐ Mycotoxin testing
- ☐ DUTCH test
- ☐ Genetics/SNPs
- ☐ Imaging: MRI/CT/ultrasound
- ☐ Sleep study
- ☐ Other specialty testing

List major abnormal findings you already know about and approximate date of testing:

What records are you submitting with this intake?

Readiness, Priorities & Planning

- ☐ Ready to change food choices
- ☐ Ready to track water/hydration
- ☐ Ready for stress/nervous system work
- ☐ Ready to take supplements consistently
- ☐ Need accountability
- ☐ Prefer aggressive approach
- ☐ Sensitive and need low/slow plan
- ☐ Ready to prioritize protein
- ☐ Ready to improve sleep schedule
- ☐ Ready to move/exercise consistently
- ☐ Need simple first steps
- ☐ Need family support
- ☐ Prefer gentle approach
- ☐ Budget is a major consideration

Rate readiness from 1-5:

Food changes	☐	☐	☐	☐	☐
Supplement consistency	☐	☐	☐	☐	☐
Sleep routine	☐	☐	☐	☐	☐
Hydration	☐	☐	☐	☐	☐
Movement/activity	☐	☐	☐	☐	☐
Stress regulation	☐	☐	☐	☐	☐
Tracking symptoms	☐	☐	☐	☐	☐
Follow-through/accountability	☐	☐	☐	☐	☐

What feels realistic for you right now? What feels overwhelming?

Final Questions & Acknowledgment

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

What has been the hardest part of this for you?

What gives you hope right now?

What would a successful first 90 days look like for you?

Acknowledgment:

I understand this intake is used for wellness coaching, education, terrain review, and root-cause-oriented support. It does not diagnose, treat, cure, prevent, or replace medical care. I affirm that the information provided is accurate to the best of my knowledge and that I will also submit the separate Medication & Supplement List.

Client signature: **Date:**