Integrative/Functional Medicine

PREPARATORY QUESTIONNAIRE

Name: _____ Date: _____

Current Medications and/or Supplements:

Current Health Concerns:

Dental History:

Regular Brushing of teeth/ Flossing:

Dental Procedures:

Ever had mercury fillings:

Environmental/Detoxification History:

Please describe any other Exposures or Sensitivities:

Please describe any other exposures not mentioned above:

Significant exposure to other harmful chemicals:

Exposure to Pets or Farm Animals:

Location where animals live:

Do you think that you have been exposed to mold in your environment?

Are there areas in your house that you feel worse?

Have you been exposed to any recent flooding?

Sleep –

Approximate number of hours asleep?

How long does it take to get to sleep?

Number of night awakenings?

Approximate time you awaken in morning?

Do you snore?

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Do you feel refreshed in the morning?

Daytime sleepiness?

Rate percentage of normal functioning
(100% being expected normal) for the following areas (scale 0 - 100%):

Cognitive: Physical: Emotional:

Concerns/Symptoms
What concerns you the most at this time?

When did your symptoms first present?

When did your symptoms start to worsen?

Was this associated with any possible triggers- explain

How have you been previously treated for this condition

Please select the appropriate response or answer:

Are you having difficulty with taking in a deep breath?

Do you experience pain on the bottoms of your feet?

Do you experience burning or painful skin sensation?

Do you experience sweats?

Any significant bloating and/or abdominal pain? If so, where?

Consistency of your bowel movement?

How often are you having a bowel movement?

Diet - How often do you eat the following:
Green Vegetables:

Fast food:

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Fried Foods:

Gluten:

Sugar:

Do you have any dietary restrictions- if so explain

Have you ever been tested for the following? and if so write the results

Heavy Metals

Stool Studies

Nutritional Evaluations

Mold Toxicity

MTHFR

Interventions - Have you EVER taken antibiotics for any reason? If so describe frequency of use and indication.

Infancy or Childhood

Teen

Adulthood

Toxicity - Have you ever had any of the following:

Folic acid treatment

IV Glutathione

IV Myer's Cocktail

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Please list the name of all the physicians involved in your care:

Women Only – Please briefly answer the following:

Been Pregnant: **Yes or No**

Number of Live Births:

Approx. Date of First Period:

Date of last menstrual period:

Typical length of your menstrual cycle in days:

Elapsed time between menstrual cycles in days:

Contraceptives Used:

Symptoms associated with menopause:

Currently in Menopause: **Yes or No**

Surgical menopause - surgical ovary removal:

Hormone replacement therapy:

Sexually transmitted diseases:

Pap Smear:

Mammogram:

Bone Density:

Number of Pregnancies:

Number of Miscarriages:

Number of Abortions:

Number of Vaginal Deliveries:

Number of Cesarean Births:

Number of Term Births:

Number of Premature Births:

Birth Weight of the smallest baby:

Birth Weight of your largest baby:

Describe any other problems during your periods:

Date of final menstrual period: