

Date ____/____/____ Male ____ Female ____ Date of Birth ____/____/____

Your Name (Last, First, MI) _____, _____, _____

Address _____

City _____ State _____ Zip _____

Cell Phone () _____ - _____ Home Phone () _____ - _____

My Private E-mail address _____

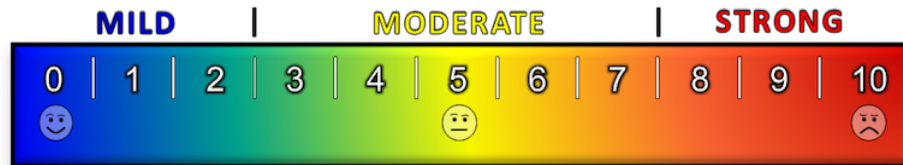
Primary problem _____ Second problem _____

Length of time with primary condition? _____ Length of time with secondary condition? _____

How did you hear about Millar Functional Medicine? _____ Have you visited our website? Y N

What is your occupation? _____ Who referred you to us? _____

**Use the 0-10 chart
to estimate your overall
Symptom Burden Score**
Please Circle A Number



Other problems I have or I think I have: (check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Issues/CAD | <input type="checkbox"/> PAD |
| <input type="checkbox"/> Adrenal Problems | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Hormone Issues | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> IBS/IBS-C/IBS-D | <input type="checkbox"/> Skin Issues |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Diabetes Pre-Diabetes | <input type="checkbox"/> Liver Issues | <input type="checkbox"/> Stroke Issues |
| <input type="checkbox"/> Anxiety Depression | <input type="checkbox"/> Edema | <input type="checkbox"/> Long COVID | <input type="checkbox"/> Tic Borne Diseases |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Female Issues | <input type="checkbox"/> Lung Issues | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Auto Immune Diseases | <input type="checkbox"/> Fibromyalgia/FMS | <input type="checkbox"/> Male Issues | <input type="checkbox"/> Toxic Issues |
| <input type="checkbox"/> Bacterial Infection | <input type="checkbox"/> Gallbladder Issues | <input type="checkbox"/> Migraines | <input type="checkbox"/> Weight Issues |
| <input type="checkbox"/> Brain Issues/Memory | <input type="checkbox"/> Gut/Stomach Issues | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Viral Infection |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other _____ |

I describe my symptoms as: _____

I have been to other Functional Medicine, Alternative or Holistic Medicine doctors?: ☐ Yes ☐ No

Name: _____ City _____ State _____

I have a primary care physician: ☐ Yes ☐ No

You are attending as our guest, a Free Talk/ Lecture/ Seminar/or Consultation hereafter "Consultation". I understand that this Consultation is at (No Charge) to me and all other services are at regular fees. The Consultation is not a new patient examination or treatment and only a meeting with the Doctor. I give my informed consent to have the Consultation, history, basic workup and whatever test may be ordered as a result of the Consultation. Results Vary Patient to Patient. The Consultation does NOT establish a patient Doctor relationship and to become a patient of Millar Functional Medicine you must complete, in full, all intake forms to the satisfaction of MFM and be accepted as a patient by the doctor.

Dr. Greg Millar, DC PhD CPM • Dr. Bonnie Sims, ND M.Div • Dr. Helen Stoddart, MD

Do Not Write On This Side: For Office Use Only

Doctor: _____ Date: _____ Give them intake package: ☐ Yes ☐ No

1. What made you decide to reach out to us out at this time? _____
2. What is _____ (problem) preventing you from doing? _____
3. What is the number one thing you need or want? _____
4. What's your biggest fear? _____
5. What do you deeply desire about your health? _____
6. What have you tried in the past? _____
7. After trying all that what did you hate the most? _____

Imagine where you will be if you don't treat or fix your _____ problem? _____

Working Problem list:

- | | |
|----------|----------|
| 1) _____ | 2) _____ |
| 3) _____ | 4) _____ |

Test Needed:

- | | |
|----------|----------|
| 1) _____ | 2) _____ |
| 3) _____ | 4) _____ |

Referrals:

Comments:

☐ Seminar ☐ Talk ☐ Webinar ☐ Internet ☐ FB Group | ☐ Physical Practice ☐ Virtual Practice
☐ FreeConsult #1 ☐ FreeConsult #2 ☐ FreeTelephoneConsult #1 ☐ FreeTelephoneConsult #2