Consultation

Millar Functional Medicine

Office Use Only:
_____ Scheduling Fee $30
☐applied to intake ☐refunded
by _____ Date_____

Date _____/_____/_____ ☐ Male ☐ Female Date of Birth _____/_____/_____

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

Address _____

City _____ State _____ Zip _____

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

My Private E-mail address _____

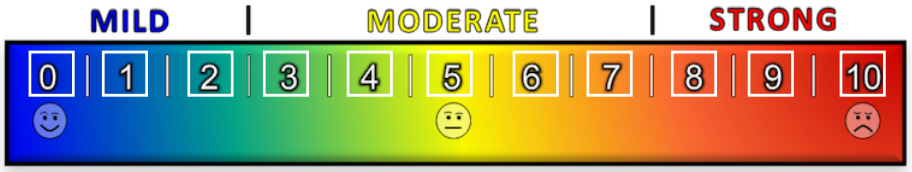
Primary problem _____ Second problem _____

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)

☐Acid Reflux/GERD	☐Chronic Fatigue	☐Heart Issues/CAD	☐PAD
☐Adrenal Problems	☐Chronic Illness	☐Hormone Issues	☐Parkinson's
☐ADD/ADHD	☐Chronic Pain	☐IBS/IBS-C/IBS-D	☐Skin Issues
☐Allergies	☐Circulation Issues	☐Kidney Issues	☐Sleep Issues
☐Alzheimer's/Dementia	☐Diabetes | Pre-Diabetes	☐Liver Issues	☐Stroke Issues
☐Anxiety | Depression	☐Edema	☐Long COVID	☐Tic Borne Diseases
☐Arthritis	☐Female Issues	☐Lung Issues	☐Thyroid Problems
☐Auto Immune Diseases	☐Fibromyalgia/FMS	☐Male Issues	☐Toxic Issues
☐Bacterial Infection	☐Gallbladder Issues	☐Migraines	☐Weight Issues
☐Brain Issues/Memory	☐Gut/Stomach Issues	☐Multiple Sclerosis	☐Viral Infection
☐Cancer	☐Headaches	☐Neuropathy	☐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 CPFM • Dr. Bonnie Sims, ND M.Div • Sandra Boldog, BSN RN

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