

David Hompes Functional Medicine

New Client Paperwork

Name:				Date:	
Address:			Country:		
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone					
Age:	Birth date:		Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:			Years Employed:
Spouse's Name:		Occupation:		Employer:	
Person responsible for this account:				Referred by:	
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize The Natural Path to release my personal medical information to me.

Patient's Signature: _____

Date: _____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ **Height** _____ **Blood Pressure** (if known) _____ **% Body Fat** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
please list (attach sheet if necessary)

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.): _____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you “miss” these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

12. What methods have you tried to lose/gain weight? _____

13. How is your energy level? _____

a. Are there times in the day that you feel best? _____ worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress? _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes _____ No _____

e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

j. I often find myself irritable or angry. Yes _____ No _____

18. Check off any of the following that have applied to you within the last 30 days:

- | | |
|---|---|
| <input type="checkbox"/> Do you feel nauseous? | <input type="checkbox"/> Do you have abdominal/intestinal pain? |
| <input type="checkbox"/> Do you have bloating? | <input type="checkbox"/> Do you get bloated after meals? |
| <input type="checkbox"/> Do you get heartburn? | <input type="checkbox"/> Do you have diarrhea? |
| <input type="checkbox"/> Do you have constipation? | <input type="checkbox"/> Do you travel outside of the U.S.? |
| <input type="checkbox"/> Do you have gas? | <input type="checkbox"/> Are your stools compact/hard to pass? |
| <input type="checkbox"/> Do you belch following meals? | <input type="checkbox"/> Do you have gurgles in your stomach? |
| <input type="checkbox"/> Do your bowel movements alternate between constipation and diarrhea? | |

24. In your estimation, how physically fit are you right now?

Unfit Below average Average Above average Very fit

25. How often do you exercise? _____

a. What is your regime? _____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

27. What are your fitness goals? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> General fitness endurance | <input type="checkbox"/> Muscle toning |
| <input type="checkbox"/> Weight loss/maintain weight | <input type="checkbox"/> Muscle strengthening |
| <input type="checkbox"/> Osteoporosis prevention | <input type="checkbox"/> Muscular coordination/balance |
| <input type="checkbox"/> Specific sport enhancement | Other _____ |
| <input type="checkbox"/> Flexibility | _____ |

28. Surgeries, starting with most recent: _____

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:

Now Past **Satisfactory**
Now Past **Boring**
Now Past **Demanding**
Now Past **Unsatisfactory**

Do you worry over:

Now Past **Home life**
Now Past **Marriage**
Now Past **Children**
Now Past **Job**
Now Past **Income**
Now Past **Money problems**

Do you often:

Now Past **Feel depressed**
Now Past **Have anxiety**

Do you often:

Now Past **Have irrational fears**
Now Past **Feel upset**
Now Past **Feel things go wrong**
Now Past **Feel shy**
Now Past **Cry**
Now Past **Feel inferior**

Have you:

Now Past **Seriously considered suicide**
Now Past **Attempted suicide**