

Functional Medicine Assessment Patient Questionnaire

File # _____ Attending Provider _____ Diagnosis _____

Comment _____

DO NOT WRITE ABOVE THIS LINE OFFICEUSE ONLY

Patient Name _____ Date _____

Chief Complaint _____

_____ Ethnicity _____

Birth Date _____ (M)ale/(F)emale _____ Household Income _____

No. Household Members _____ Highest Education Level _____ (M)arried/(S)ingle _____

Nutrition

- | | | | |
|-----|---|-----|----|
| a1) | Do you eat seven or more meals per week away from home? | Yes | No |
| a2) | Do you eat three or more portions each of fruits and vegetables every day? | Yes | No |
| a3) | Do you principally eat whole-grain (not white flour) products? | Yes | No |
| a4) | Do you regularly consume more than two portions of whole-fat dairy products per day (i.e., whole milk, cheese, ice cream, butter, whole milk yogurt)? | Yes | No |
| a5) | Do you battle your weight with routine dieting? | Yes | No |
| a6) | Are you on a special diet (macrobiotic, vegetarian, vegan, etc.)? | Yes | No |

Genetics/Family & Birth History

- | | | | |
|-----|--|-----|----|
| b1) | Do any particular medical problems run in your family? | Yes | No |
| b2) | Were there any significant problems associated with your gestation (your mother's pregnancy with you)? | Yes | No |
| b3) | Were there problems at your birth? | Yes | No |

Environment

- | | | | |
|-----|--|-----|----|
| c1) | Do you react adversely when you consume caffeinated beverages? | Yes | No |
| c2) | Do you react adversely to any food? | Yes | No |
| c3) | Do pesticides, cigarette smoke, perfumes/colognes, or auto exhaust fumes significantly affect you? | Yes | No |
| c4) | Are you significantly bothered by video display terminals and fluorescent lights? | Yes | No |
| c5) | In your work or home environment, are you exposed to chemicals or electromagnetic radiation? | Yes | No |

Psycho-Social

d1)	Do you feel significantly less vital than you did a year ago?	Yes	No
d2)	Are you happy?	Yes	No
d3)	Do you feel your life has meaning and purpose?	Yes	No
d4)	Do you believe stress is presently reducing the quality of your life?	Yes	No
d5)	Do you like the work you do?	Yes	No
d6)	Do you have a satisfactory sex life?	Yes	No
d7)	Have you ever been hospitalized for mental or emotional illness?	Yes	No
d8)	Have you ever experienced major losses in your life?	Yes	No
d9)	Do you spend the majority of your time and money to fulfill responsibilities and obligations?	Yes	No
d10)	Would you describe your experience as a child in your family as happy and secure?	Yes	No

Lifestyle Choice

e1)	Do you smoke or use tobacco in any form regularly/daily?	Yes	No
e2)	Do you regularly drink two or more alcoholic beverages per day?	Yes	No
e3)	Do you consume caffeine on a daily basis?	Yes	No
e4)	Do you regularly practice any form of stress reduction, yoga, or meditation?	Yes	No
e5)	Do you use any recreational drugs other than alcohol?	Yes	No

Exercise/Aerobic Conditioning

f1)	Do you regularly exercise three or more times per week for 20 minutes or more each time?	Yes	No
f2)	Does your present physical condition limit your physical activity?	Yes	No
f3)	Do you feel unusually fatigued after exercise?	Yes	No

Women Only

g1)	Do you experience regular problems with PMS?	Yes	No
g2)	Do you regularly have problems with menstrual cramps?	Yes	No
g3)	Do you experience irregular menstrual cycles?	Yes	No
g4)	Do you experience heavy menstrual periods?	Yes	No
g5)	Have you entered menopause?	Yes	No
g6)	Do you regularly experience breast problems, pain, lumps, nipple discharge?	Yes	No
g7)	Are you pregnant?	Yes	No

Men Only

h1)	Do you have trouble starting your urine, frequent urination pain, or pain in the area of your prostate gland?	Yes	No
h2)	Do you experience sexual dysfunction?	Yes	No

General

i1)	Are you currently taking prescription or nonprescription drugs?	Yes	No
i2)	Have you been hospitalized for a serious illness or trauma?	Yes	No