

Functional Diagnostic Medicine:

Patient Intake, Health and Medical History Form

Please complete the following life history questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help me evaluate the root cause of your health concerns and determine an effective treatment program.

Note that I am interested in so-called minor symptoms as well as major problems. I know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in my office are different. I am interested in any odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" I do. Please include as much information as you can on this form.

Please print or write legibly and FILL OUT BOTH THE ENTIRE FORM.

Today's Date: _____

Last Name:	Middle:	First Name:
Home Address:		
City:	State:	Zip:
Date of Birth:	Age:	Height:
		Weight:
		Blood Type:
Who Referred You to Me?:		Marital Status (Circle): Single, Married, Divorced, Widowed
Occupation:		Primary/current treating physician:
Circle: Full Time/Part Time		
Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):		Phone number and/or address of physician:

- YES, NO I authorize the following telephone numbers
- YES, NO I authorize the use of my address for mailing
- YES, NO I authorize the use of my email address for announcements and newsletters
- YES, NO I authorize Optimum Function to contact the necessary health care providers to obtain pertinent health information.

Email and Phone Numbers:

Email: _____ Home Ph: _____

Cell: _____ Work _____

Indicate if you have a preferred mailing address:

Signature: _____

Date: _____

I may need to leave messages, return telephone calls, and send office mail to your home address as part of my normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call.

Your agreement will allow me to use your name, email address and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. I will use your email address home address, noted to the left, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form.

This authorization may be revoked by you at any time, by advising me (Dr. Irving) of this revocation in writing or email.

Health Care Providers seen:

Start with the provider that is most pertinent but list **all** providers (all types of doctors or therapists), up to your last provider seen, and check all that apply for each. Be certain to list these in sequence from first to last.

① Name hospital/doctor/therapist/center: _____
Address and/or phone number: _____ Date _____

Indicate what was done:

<input type="checkbox"/> Exam-consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Exercises
<input type="checkbox"/> Exam or consult only (no treatment)	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> X-ray of neck or head	<input type="checkbox"/> Spinal adjustments	<input type="checkbox"/> Injection(s)
<input type="checkbox"/> X-ray of chest/ribs/middle back	<input type="checkbox"/> Muscle massage/myotherapy	<input type="checkbox"/> Wrist brace-splint
<input type="checkbox"/> X-ray of low back/ pelvis/hips	<input type="checkbox"/> Muscle stimulation	<input type="checkbox"/> Neck collar (brace)
<input type="checkbox"/> X-ray of shoulder/arms/legs	<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Low back brace
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Anti-inflammatory medications	<input type="checkbox"/> Heat packs
<input type="checkbox"/> EMG/Nerve conduction study	<input type="checkbox"/> Pain medications	<input type="checkbox"/> Ice packs
<input type="checkbox"/> Other tests	<input type="checkbox"/> Muscle relaxants	<input type="checkbox"/> Other: _____

Indicate if treatment with this provider: Helped, Did not help, Made condition worse

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Address and/or phone number: _____ Date _____

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PAST MEDICAL & SURGICAL HISTORY CONTINUED

DIAGNOSTIC STUDIES	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan				
Liver scan				
Bone scan				
X-rays				
Bone Density Test				
Blood Tests				
Other				
OPERATIONS				
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Other				

MEDICATION LOG

Medications: What medications are you taking now? Include non -prescription drugs?

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name	Date started	Dated Stopped	Dosage	# per day

FAMILY GENETICS

(Place mark any health problem(s) your family has suffered with either now or in the past)

Present Age	Father	Mother	Grandmother (father's side)	Grandfather (father's side)	Grandmother (mother's side)	Grandfather (mother's side)
If deceased, what age?						
Heart Attack						
Stroke						
Uterine Cancer						
Emphysema						
Arthritis						
RA						
Lupus						
Diabetes						
Parkinson's						
Alzheimer's						
Osteoporosis						
Glaucoma						
Colon Cancer						
Breast Cancer						
Prostate Cancer						
High Blood Pressure						
Skin Cancer						
Depression						
MS						
Alcohol Addiction						
Smoking Addiction						
Asthma						
Pneumonia/ Bronchitis						
Obesity						
Flu						
Headache						
Insomnia						
High Cholesterol						
Other						

REVIEW OF SYSTEMS:

Check only those items with which you recognize, indicate past or present for anything that you have experienced .
Ignore anything that does not apply to you .

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Night Walker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted Vision

SKIN

- Cuts Heal slowly
- Bruise Easily
- Rash
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Cracking skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Have bumps on the back of arms and front of thighs
- Skin Cancer
- Strong body odor

Is you skin sensitive to the:

- Sun
- Fabrics _____
- Detergents _____

HEAD/MIND:

- Poor Concentration
- Confusion
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Concussion/Whiplash
- Face Twitch
- Poor Memory
- Hair Loss

HEAD/MIND continued

- Headaches:
- After Meals
- Severe
- Migraine
- Frontal
- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Caused by:

EYES:

- Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights
- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes
- Visual hallucinations

Ears:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Wear a hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing Hallucinations

Nose/Sinuses

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- Spring
- Summer
- Fall
- Winter

MOUTH:

- Coated Tongue
- Sore Tongue
- Teeth Problems
- Bleeding Gums
- Canker Sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

THROAT:

- Mucus
- Difficulty Swallowing
- Frequent Hoarseness
- Tonsillitis
- Enlarged Glands
- Constant clearing of throat
- Throat closes up

NECK:

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION:

- Swollen Ankles
- Sensitive to Hot
- Sensitive to Cold
- Extremities Cold or Clammy
- Hands/Feet go to sleep/numb
- High Blood Pressure
- Chest Pain
- Pain between shoulders
- Dizziness upon standing
- Fainting Spells
- High Cholesterol
- High Triglycerides
- Wheezing
- Irregular Heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently Sighing
- Shortness of breath
- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack ?? When _____
- Phlebitis
- Spider Veins

GASTROINTESTINAL/DIGESTION

- Peptic/Duodenal Ulcer
- Poor Appetite

GASTROINTESTINAL/DIGESTION continued

- Excessive Appetite
- Gallstones
- Gallbladder pain
- Nervous Stomach
- Full Feeling after meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting Blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in Bowels
- Rectal Bleeding
- Tarry Stools
- Rectal Itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

KIDNEY/URINARY TRACT:

- Burning
- Frequent Urination
- Blood in Urine
- Night time Urination
- Problem Passing Urine
- Kidney Pain
- Kidney Stones
- Painful Urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

REPRODUCTIVE SYSTEM:**MALE:**

- Lumps in testicles
- Sore on penis
- Erection Problems
- Impotence
- Diminished Sex drive
- Hernia
- Enlarged Prostate
- Prostate Cancer
- Low Sperm Count
- Infertility
- Poor Libido
- Genital Pain

FEMALE

- Fibroid Tumors/Breast
- Fibroid Tumors/Uterus
- Lumps in Breast
- Breast soreness before period
- Breast soreness during period
- Breast Cancer
- Ovarian Cysts
- Vaginal Discharge
- Non-Period Bleeding

FEMALE continued

- Spotting
- Hot flashes
- Diminished sex drive
- Change in period
- Endometriosis
- Pregnant
- Infertility
- Had partial/total hysterectomy
- Had breast biopsy
- Had miscarriage
- Use contraceptive pill
- Age you began menses? _____
- Age at menopause? _____
- Are you taking hormone replacement therapy?

If yes, what medication?

- Estrogen
- Estrace
- Premarin
- Ogen
- Progesterone
- Provera
- Other _____
- Other _____

Date of last PAP SMEAR? _____

JOINT/MUSCLES/TENDONS

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

AGE

Please list the age(s) you had or suffered from the following:

- _____ Frequent colds or flu
- _____ Tonsillitis
- _____ Bronchitis
- _____ Ear Infections
- _____ Measles
- _____ Mumps
- _____ Chicken Pox
- _____ Whooping Cough
- _____ Frequent Antibiotics
- _____ Strep Infections
- _____ Seasonal allergies
- _____ Significant dental work
- _____ Behavior problems
- _____ ADD
- _____ Hyperactivity
- _____ Difficulty learning:
- _____ Frequent headaches
- _____ High # of absences from school
- _____ Upset stomach, indigestion
- _____ Jaundice
- _____ Colic
- _____ Ear infections
- _____ Congenital abnormalities
- _____ Premature at birth
- _____ Pneumonia
- _____ Fever blisters
- _____ Parent (s) smoked
- _____ Abusive or alcoholic parent (s)

- _____ Skin disorders (eczema)
- _____ Major illness(s) that require hospitalization

If yes, please explain your illness:

MENTAL/EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently "wired" and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Nervous breakdown
- Had "burnout"
- Short attention span
- Vision changes
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory

DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income
- Money Problems

TOXIC STRESS TRIGGERS

(These refer to on-going stress that has accumulated over months or years. Please mark any of the above that you have experienced in your lifetime)

- Childhood traumas
- Are you a "perfectionist"?
- Divorce or change in a relationship
- Caregiving: *taking care of a sick family member*
- Job or career challenges
- Illness, either short-term or chronic
- Dieting: *constantly trying a "new and improved" diet program*
- Menopause

Please use this space to explain, expand upon or list anything else about your health that you feel is pertinent:

Thank you for taking the time to complete this health history medical questionnaire.

If you have not completed the other questionnaires I gave you then please do so now. The information derived from all of these medical forms will provide **invaluable data**.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the **"missing key"** that will help **solve** your health problem.


Once all of the forms and questionnaires have been filled out please either return them to me at my office, fax them to 503-716-4575 or email them to forms@optfunction, before your initial appointment if possible. If I am out of the office, you can slip your paperwork under the door.

I thank you once again and look forward to helping you achieve **Optimum Function**.

Remember:

Optimum Function= Optimum Health

Yours in Health,



D.C., L.M.T

Dr. Tim Irving DC, LMT