Functional Medicine New Patient Health Intake Form

Section 1: Basic Information

Full name: _____

Date of birth: _____ Age: _____

Email: _____

Phone: _____

How did you hear about this practice? _____

Primary reason for seeking care: _____

Section 2: Chief Complaint

What is your main health concern?

_____

_____

When did this start?

□ < 3 months □ 3-12 months □ 1-3 years □ > 3 years

How would you rate the severity?

□ Mild □ Moderate □ Severe

What have you tried so far? (check all that apply)

□ Conventional medicine □ Supplements / herbs

□ Diet changes □ Nothing yet

□ Other: _____

Section 3: Symptom Checklist

Check all symptoms you experience regularly:

Digestive:

□ Bloating □ Acid reflux □ Constipation □ Diarrhea

□ Food sensitivities □ Nausea □ Abdominal pain

Energy & Mood:

□ Fatigue □ Brain fog □ Anxiety □ Depression

□ Sleep issues □ Irritability □ Difficulty concentrating

Musculoskeletal:

□ Joint pain □ Muscle aches □ Stiffness

□ Back pain □ Muscle weakness

Skin:

□ Acne □ Eczema □ Rashes □ Dry skin □ Hair loss

□ Brittle nails □ Skin discoloration

Hormonal (if applicable):

□ Irregular cycles □ PMS □ Hot flashes

□ Low libido □ Night sweats □ Heavy bleeding

Immune:

□ Frequent infections □ Autoimmune diagnosis

□ Seasonal allergies □ Slow wound healing

□ Chronic inflammation

Section 4: Lifestyle & Diet

Describe your typical daily diet:

_____

_____

Water intake: _____ glasses per day

Caffeine: _____ cups per day

Alcohol: _____ drinks per week

Exercise: _____ times per week

Type of exercise: _____

Sleep: _____ hours per night

□ Fall asleep easily □ Wake during the night □ Wake up tired

Stress level (1-10, 10 = highest): _____

Primary stress sources (check all that apply):

□ Work □ Family □ Health □ Finances □ Other

Occupation: _____

Typical work hours: _____

Section 5: Medical History

Current medications (list all, including dosage):

_____

_____

Current supplements (list all, including dosage):

_____

_____

Past surgeries (type and year):

_____

Diagnosed medical conditions:

_____

_____

Allergies (medication, food, environmental):

_____

Family history (parents/siblings — check all that apply):

□ Autoimmune disease □ Thyroid disease □ Diabetes

□ Heart disease □ Cancer □ Mental health condition

□ None of the above

Section 6: Previous Testing & Providers

Have you had recent lab work?

□ Yes (approximate date: _____) □ No

If yes, do you have copies of your results?

□ Yes □ No □ I can request them

Types of practitioners you have seen for your health concerns:

□ Primary care physician □ Gastroenterologist

□ Endocrinologist □ Naturopathic doctor

□ Functional medicine doctor □ Chiropractor

□ Acupuncturist □ Nutritionist / Dietitian

□ Other: _____

Is there anything else you would like us to know before your appointment?

_____

_____

_____