Functional Medicine Intake Form

Patient First Name

Patient Middle Name

Patient Last Name

Patient Preferred Name

Address

Address 2

City

State

Zip

Cell Phone

Sex

☐ Male ☐ Female ☐ Other

Explain

Martial Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Age

Date of Birth

Race

☐ White

☐ Black/African American

☐ Asian

☐ American Indian/Alaska Native

☐ Native Hawaiian/Other Pacific Islander

☐ Other

☐ Unreported/Declined to Report

List

Ethnicity

☐ Hispanic or Latino

☐ Non Hispanic or Latino

☐ Unreported/Declined to Report

Email Address

Occupation

Emergency Contact First Name

Emergency Contact Last Name

Emergency Contact Phone

Emergency Contact Reletionship

How did you hear about us?

Are you under the care of a qualified healthcare professional? If so, list their name.

Please bring any blood work results if you had those done with your PCP in the last 6 months to 1 year.

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change.

I acknowledge the above statement above.

Signature

Medical History

Please list any medical conditions a medical provider has diagnosed you with in the past: (such as high blood pressure, diabetes, arthritis, etc.)

What medications, supplements and over the counter items do you take regularly or are currently prescribed:

Any past surgeries and/or hospitalizations?

Please describe your family history in terms of heart disease, diabetes, obesity, high cholesterol, high blood pressure, and cancer:

What are your main interests and hobbies?

What is your line of work or study?

Do you exercise regularly? Please detail.

What kind of other movement or activities do you enjoy?

You have problems falling or staying asleep?

☐ Yes ☐ No

How many hours do you sleep per night?

☐ Less than 4 hrs ☐ 5-6 hrs ☐ 7-8 hrs ☐ 9-10 hrs ☐ 11+ hrs

Do you wake up feeling refreshed?

☐ Yes ☐ No

How are your energy levels?

☐ Very Low ☐ Low ☐ Moderate ☐ High

Does your energy levels affect your daily activities?

☐ Yes ☐ No

Does your mood affect your life or daily activities?

☐ Yes ☐ No

How would you describe your general mood?

How would you describe your stress levels?

☐ Low ☐ Moderate ☐ High

What are your sources of stress?

How do you manage stress?

Do you have people close to you who support you?

☐ Yes ☐ No

Health History

Have you experienced:

Fatigue
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Unexplained weight loss or gain
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Change in appetite
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Depressive symptoms
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Anxiety
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Mood swings
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Nervousness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Addictive dependency
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Disordered eating patterns/tendencies
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Tension
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Lack of mental focus
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Thyroid problems
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Diabetes
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Blood sugar irregularities
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Excessive thirst or hunger
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Sugar cravings
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abnormal hair growth
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Excessive perspiration
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Feeling excessively hot or cold
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Headache
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Lightheadedness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Joint pain or stiffness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Muscle weakness or soreness
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

High blood pressure
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Heart murmur/palpitations
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Cold or pale extremities
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Asthma
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Shortness of breath
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Heartburn
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abdominal discomfort after eating
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Nausea
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Abdominal bloating
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Belching or excessive gas
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Constipation
☐ No, never ☐ Yes, currently
☐ Not currently, but within the last year
☐ No currently, but longer than 1 year ago

Consent

CONSENT FOR CARE TREATMENT

I, the undersigned do hereby agree and give consent to providers with Lakeside Integrative Healthcare, to furnish treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Name _____ **Date of Birth** _____

Patient's Signature

Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Privacy & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.
  I acknowledge that I have reviewed your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices.I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do not agree that you are bound to abide by such restrictions.

Signature

Date

Patient Consent

PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Lakeside Integrative Health Care, to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Lakeside Integrative Health Care, Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to singing this consent. Lakeside Integrative Health Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Lakeside Integrative Health Care

With this consent form, Lakeside Integrative Health Care, may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory results, among others.

With this consent form, Lakeside Integrative Health Care, may mail, to my home or other alternative location, any items that assist in carrying out treatment, payment or healthcare operations such as appointment reminder cards and patient statements as long as they are marked personal and confidential. With this consent form, Lakeside Integrative Health Care, may email, to my home or other alternative location, any items that assist the practice in carrying out treatment, payments or healthcare operations such as appointment reminders. I have the right to request that Lakeside Integrative Health Care, restrict how it uses or discloses my protected health information (PHI) to carry out treatments, payments and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Lakeside Integrative Health Care, use and disclosure of PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Lakeside Integrative Health Care, may decline to provide treatment for me.

Name

Signature

Date

Clinic Policies

Lakeside Integrative Healthcare Clinical Policies

If you have any questions, please feel free to ask us.

- If you are late or miss your appointment, you may be subject to a $50 fee.
- Services must be paid for at the time of service.
- Health insurance typically does not cover the services provided at Lakeside Integrative Healthcare. If you want to seek insurance reimbursement, we would be happy to provide you with itemized invoices that you can submit to your insurance company.
- Phentermine and Vyvanse are considered controlled substances. I agree that I will take my medications as prescribed. I agree to follow my medical providers instructions. I also agree that I will not sell or share my prescriptions to other individuals.
- I understand that treatments used at Lakeside Integrative Healthcare might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life through hormone restoration, nutritional and supplemental counseling, and weight loss treatment.
- I agree that if I have any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.
- I acknowledge that Lakeside Integrative Healthcare are not my primary care providers unless I elect them so. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed at Lakeside Integrative Healthcare.
- I understand that there are no refunds for services or products rendered. We cannot accept back used medications once they have been dispensed per state regulation.
- I understand that having an appointment with Lakeside Integrative Healthcare does not necessarily entitle me to being issued a prescription for hormone replacement, weight loss medication or additional medications. Every individual is different, and it is at the medical providers discretion to issue a prescription.

- I understand that I must maintain my follow-up appointments to remain on treatment. It is important that lab work is monitored regularly for safety purposes. It is important that a Lakeside Integrative Healthcare provider manages my treatment, and it is at their discretion to provide treatment.

- I acknowledge that I have been advised of the risks and benefits of treatment. I also acknowledge that I have been advised of possible complications and side effects. I understand the risks, benefits, complications, and side effects of treatment.

- I am voluntarily requesting treatment with Lakeside Integrative Healthcare and its medical providers regarding weight loss therapy as determined by a mutual decision between myself and the medical provider even if my hormone levels are considered to be in normal range for my age based off of other medical society recommendations and guidelines or if I am just considered overweight and not obese.

- I do not hold any medical practitioner of Lakeside Integrative Healthcare responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Lakeside Integrative Healthcare and its medical providers harmless if an adverse event occurs during my treatment. I will ensure that my primary care provider provides the results of such screenings to Lakeside Integrative Healthcare as this could change the treatment prescribed to me.

I have read, understand, and agree to all the above statements.
Patient Name

Signature