FUNCTIONAL MEDICINE INITIAL INTAKE FORM

Directions: Please fill in this questionnaire and bring it to your INITIAL CONSULTATATION or if possible scan back to Lisa@Killah.org.

CLIENT INFORMATION							
Your Name:						**Date:**	
Address:							
Phone				**D.O.B.**			
E-mail address							
Age		**Sex**		**Marital Status**		**# of children**	
Height (cm)		**Weight (kg)**			**Goal Weight (kg)**		
Occupation							
Typical tasks you do on the job *(including any chemicals you may handle)*							
Hobbies							

QUESTIONS
1. **What are the top 3 symptoms currently bothering you (i.e. fatigue, brain fog, menstrual cramps, hot flashes, depression, gas & bloating, thinning hair, allergies, etc)?**
2. **Please list any additional symptoms that are bothering you and/or any health conditions you have been diagnosed with (i.e. Type II Diabetes, Hypothyroidism, PCOS, Crohn's, etc)**
3. **When did these problems start? Around the time the symptoms first developed, was there a major emotional stress going on in your life (divorce, birth of a child, job change, death of a loved one, accident, trauma, etc.)**
4. **What do these health problems prevent you from doing?**
5. **What have you tried for these problems that *have* or *have not* helped? *(i.e. supplements, medications, therapies such as chiropractic, etc.)***
6. **When was the most stressful period in your life, and did this coincide within a year or two with the development of <u>any</u> health problems?**

7. Describe your current diet *(i.e. gluten-free, dairy-free, low-carb, Paleo, organic, vegetarian, vegan, etc.)*, what foods you commonly eat or exclude, how often you eat out at restaurants, etc. How long have you been following this diet (i.e. how long have you been gluten-free, vegetarian, etc)?	
8. Where do you typically shop for groceries (food)? *(i.e. Cub Foods, Trader Joe's, Costco, Whole Foods, Natural Food Co-op, Fresh & Natural Foods, Farmer's Market, Online, etc)*	
9. How many meals and snacks do you typically eat each day? Do you feel shaky or sick if you don't eat on time or you don't snack?	
10. What foods do you tend to overeat or crave (sweets, chocolate, milk, fatty food, bread, etc.)?	
11. When (what time) do you typically:	
Wake up in the morning?	
Eat breakfast?	
Eat lunch?	
Eat a snack (or snacks)?	
Eat dinner?	
Go to bed?	
12. How often do you have a bowel movement (multiple times a day, once a day, every 2-3 days, once a week)? Do you experience constipation or diarrhea?	
13. How much water do you drink daily? What type of water do you drink (tap, bottled, filtered, distilled, well)?	
14. How often do you drink caffeinated beverages (coffee, energy drinks)? What happens if you don't drink them?	
15. List all <u>hormones</u> (prescription and non-prescription / synthetic and bioidentical) that you are currently taking and the dosage – *such as Estrogen, Progesterone, Testosterone, Pregnenolone, DHEA, Melatonin, and Thyroid*. *[Include birth control pills and HRT]*	
16. Have you *<u>ever</u>* used a <u>bioidentical hormone cream</u> (prescription or non-prescription) with Estrogen, Progesterone, Testosterone, or DHEA? If yes, then how long ago did you last use it (currently using, days ago, weeks ago, months ago, years ago, etc)?	

17. List all other <u>prescription medications</u> you currently take *(i.e. statins, blood pressure medication, bone loss drugs, etc.)* *(attach a separate sheet if necessary)*
18. Please list all <u>over-the-counter medications</u> you currently use on a regular basis *(aspirin, tylenol, ibuprofen, heartburn/GERD medications, topical cortisone cream, etc.)*
19. Please list all <u>nutritional supplements</u> you currently take *(vitamins/minerals, fish oil, amino acids, probiotics, herbs, etc.)*. Please include brand name and dosage.
20. Please list any food, spice, chemical, or medication to which you have had an adverse reaction?
21. Do you smoke, chew tobacco, drink alcohol, or use recreational drugs? If yes, then provide details of which of these you do, how much, and how often?
22. How much sleep do you get each night on average? What time do you typically go to bed? What time do you typically get up in the morning? Do you have trouble falling asleep or wake up in the middle of the night and can't get back to sleep?
23. How is your energy level? Are there times in the day you feel best or worst?
24. What are your main sources of stress? How do you deal with your stress?
25. FEMALES: Are you <u>pre-menopausal</u> *(still having a period)*, <u>peri-menopausal</u>, or <u>menopausal</u> *(at least 12 months since you've had a period)*?

***Pre-menopausal women:	
How long is your cycle (every 28 days, every 26 days, every 32 days, varies greatly, etc)?	
Do you experience PMS symptoms (moodiness, bloating, headaches, etc) before your period or have painful periods (cramping, etc)?	
How long does your period usually last (how many days do you experience bleeding) [3 days, 5 days, etc]?	
What was the date (i.e. June 5th) that your most recent period started ("Day 1" of your cycle = the first day of blooding)? [We need to know this to determine when you should do your adrenal/hormone test]	

26. <u>(Females)</u>: Are you currently pregnant or trying to get pregnant?
27. How often do you exercise? What types of exercise do you do?

28. Please list any surgeries and hospitalizations (and the year they occurred)?
29. What vaccinations have you received as a child or adult (MMR, DPT, Polio, Hepatitis B, Chicken Pox, Flu)? Have you had an adverse reaction to any vaccine?
30. Do you have a family history of heart disease, stroke, diabetes, cancer, autoimmune disease, thyroid disorders, obesity, or any other condition?
31. Are there any emotions (anger, fear, insecurity, guilt, worthlessness, helplessness, rejection, shame, regret, unloved, etc) that you constantly experience?
32. Are you currently under a physician's care? If so, physician's name?
33. Using a scale of 0-10, how motivated/willing are you to make dietary changes (i.e. 100% gluten-free diet), take supplements, and allow time for your body to heal? (0 = not willing to make dietary changes, don't want to take supplements, and want a "quick fix"; 10 = willing to make major dietary changes, take supplements, do whatever it takes to get well, and understanding that healing the body is a process which takes time and doesn't necessarily provide "instant" symptom relief like a drug)
34. For supplements, do you have a <u>preference</u> for the TYPE of supplements we recommend for you (capsules, chewable tablets, liquids, alcohol-containing tinctures, powders, tea, etc) or a like/dislike for any certain FLAVORS (citrus, berry, etc)? Please explain WHY if you *cannot* take certain types of supplements (difficulty swallowing capsules, sensitivity to sugar alcohols in some chewables, etc).
35. Is there anything else you would like to add that wasn't covered?

SYMPTOM SURVEY

Mark an "X" next to any of the following symptoms that you have had at some point in the past ("PAST") or currently have ("NOW")

GENERAL			JOINTS, MUSCLES, & NERVES			DIGESTION & ELIMINATION		
PAST	NOW		PAST	NOW		PAST	NOW	
		Brain Fog (difficulty thinking)			Arthritis (osteo)			Abdominal Pain
		Fatigue			Arthritis (rheumatoid)			Bloating After Meals
		Difficulty falling asleep			Fractures			Gas (Flatulence)
		Waking up in the middle of the night			Injury (back, head, neck, arm, leg, etc)			Small Amounts Of Food Fill You Up Quickly
		Sleepy During The Day			Bone Spurs			Belching
		Body Odor			Gout			Foul-Smelling Gas or Stool
		Can't Gain Weight			Bursitis			Heartburn
		Can't Lose Weight			Joint Pain			GERD / Acid Reflux
		Weight Loss (sudden/unplanned)			Joint Swelling and/or Redness			Nausea / Vomiting
					Joint Stiffness			Stomach Ulcers

HEAD, EYES, & EARS		
		Headaches (frequent)
		Migraines
		Dizziness
		Vertigo
		Faintness
		Bloodshot eyes
		Eye Twitches
		Dark Circles Under Eyes
		Vision Problems
		Cataracts
		Macular Degeneration
		Night Blindness
		Tinnitis (ringing in ears)
		Earaches / Ear Infections

SKIN		
		Acne
		Dermatitis
		Eczema
		Psoriasis
		Rosacea
		Hives
		Rash
		Itching
		Vitiligo
		Dry Skin
		Oily Skin
		Nickel Allergy
		Bumps on Backs Of Upper Arms
		Redness of Face, Ears, Nose
		Bruise Easily
		Excessive Sweating

HAIR & NAILS		
		Hair Loss
		Thinning Of the Outer Part Of Eyebrows
		Dandruff
		White Spots On Nails
		Cracked/Splitting Nails
		Ridges On Nails

		Osteopenia
		Osteoporosis
		TMJ Problems
		Tendonitis
		Muscle Pain or Stiffness
		Muscle Cramps – Calf
		Muscle Cramps – Foot
		Muscle Spasms - Back
		Muscle Weakness
		Numbness or Tingling
		Tremors
		Balance/Coordination Problems
		Restless Legs
		Carpal Tunnel Syndrome
		Sciatica

NOSE, MOUTH, & TEETH		
		Stuffy Nose
		Sinusitis
		Sinus Infections
		Bad Breath (halitosis)
		Cracks In Corners Of Mouth
		White Coating On Tongue
		Canker Sores
		Cold Sores
		Dry Mouth
		Bleeding Gums
		Bruxism (grinding teeth)
		Cavities (dental caries)
		Periodontal Disease
		Amalgams (silver fillings)
		Root Canals
		Sore Throat
		Difficulty Swallowing
		Feels Like Lump In Throat
		Clearing Throat Frequently
		Hoarseness
		Hay Fever
		Nose Bleeds
		Cold/Flu (frequent)

		Diarrhea
		Constipation
		Hemorrhoids
		Blood or Mucus In Stool
		Undigested Food In Stool
		Anal Itching
		IBS (Irritable Bowel Syndrome)
		IBD (Inflammatory Bowel Disease)
		Crohn's Disease

URINARY		
		Bladder/Urinary Infections (frequent)
		Pain/Burning
		Cystitis (interstitial)
		Frequent Urination
		Nighttime Urination
		Incontinence
		Urgency
		Bed Wetting
		Rarely Feel The Urge To Urinate
		Kidney Stones

CARDIOVASCULAR		
		Arrhythmia
		Heart Palpitations
		Heart Murmur
		Tachycardia
		Bradycardia
		Angina/Chest Pain
		Blood Fats – High (cholesterol / triglycerides)
		Atherosclerosis
		Arteriosclerosis
		Cholesterol - Low
		Cholesterol - High
		Blood Pressure - Low
		Blood Pressure - High
		Edema - Fluid Retention
		Swollen Ankles/Feet
		Varicose Veins
		Thrombophlebitis
		Cold Hands or Feet

RESPIRATORY		
PAST	NOW	
		Bronchitis
		Pneumonia
		Cough – Dry
		Cough – Productive
		Wheezing
		Asthma
		Shortness Of Breath
		Snoring
		Sleep Apnea

MOOD, MIND, & EMOTIONS		
		ADD/ADHD

DISEASES (DIAGNOSED)	
	Alcoholism
	Alzheimer's Disease
	Anemia
	Bell's Palsy
	Cancer
	Celiac Disease
	Chronic Fatigue Syndrome
	Cirrhosis
	Congestive Heart Failure
	Coronary Artery Disease
	Diabetes (Type I)
	Diabetes (Type II)

INFECTIONS		
PAST	NOW	
		Travel Outside the U.S.
		Chicken Pox
		Shingles
		Herpes
		Cytomegalovirus (CMV)
		Epstein Barr Virus (EBV) / Mononucleosis
		Yeast/Fungal Infections (athlete's foot, nail fungus, vaginal yeast infection, etc)
		Parasites / Amoebas
		"Montezuma's revenge"

		Autism		Diverticulitis / Diverticulosis			Pinworms
		Learning Disabilities		Emphysema			Worms (roundworm, etc)
		Anxiety		Epilepsy / Seizures			Bacteria
		Panic Attacks		Fibromyalgia			H Pylori
		Fearfulness		Gall Stones			Lyme Disease (or Bull's Eye Rash)
		Irritability / Easily Agitated		Glaucoma			
		Anger Episodes		Heart Attack			
		Mood Swings		Heavy Metal Toxicity (i.e. Mercury, Lead)			
		Easily Upset		Hypothyroidism	**FOOD ISSUES**		
		Feel Highly Stressed By Life / Work / School		Hyperthyroidism			Appetite - Excessive
		Depression		Goiter			Appetite - Reduced
		Suicidal Thoughts		Grave's Disease			Thirst - Excessive
		Bipolar Disorder		Hashimoto's			Blood Sugar - Low (hypoglycemia)
		Manic Depressive Disorder		Heart Attack			Blood Sugar - High
		Schizophrenia		Hemochromatosis			Gluten Sensitivity
		Hallucinations		Hepatitis			Dairy Sensitivity (or allergy)
		Phobias		Hiatal Hernia			Lactose Intolerance
		Nightmares		Leukemia			Egg Sensitivity (or allergy)
		Had any violent or highly traumatic life experiences		Liver Disease			Soy Sensitivity (or allergy)
		Impulsive Behavior		Lupus			Corn Sensitivity (or allergy)
		Difficulty Concentrating		Lymphoma			Nightshade Sensitivity
		Poor Memory		Melanoma			Carbohydrate Sensitivity
		OCD or Obsessive Thoughts		Meniere's Disease			Multiple Food Sensitivities
REPRODUCTIVE - MALE				Multiple Sclerosis			Difficulty Digesting Fats
		Benign Prostatic Hyperplasia		Muscular Dystrophy			Difficulty With Spicy Foods
		Impotency		Myasthenia Gravis			Sugar Cravings
		Infertility		Pancreatitis			Salt Cravings
		Libido – Low		Parkinson's Disease			Eating Disorder
				Scleroderma			
REPRODUCTIVE - FEMALE				Stroke	**ENVIRONMENTAL**		
		Amenorrhea (no period)		Tuberculosis			You live or work in a place that has visible or known mold (in air vents, tile grout in bathrooms, ceilings where water leaks have occurred)?
		Dysmenorrhea (painful period)					
		Menorrhagia (heavy period)					
		Irregular Periods					
		PMS					Live/work in a place that has a "musty" smell
		Hot Flashes/Night Sweats	**SURGICAL OPERATIONS**				
		Endometriosis		Appendectomy			Live/work in a place that has had flooding / water damage
		Breast Cysts or Lumps		Gall Bladder Removal			Live/work in an old building
		Ovarian Cysts / Uterine Fibroids		Hernia			You don't use a dehumidifier
		PCOS		Hysterectomy			You use plug-in air fresheners
		Infertility		Tonsillectomy			You wear perfume/aftershave
		Libido – Low		Other			You have pets
		Vaginal Discharge					

DIET

Mark an "X" next to any of the diets you have followed at some point in the past ("PAST") or are currently following ("NOW")

PAST	NOW	
		GLUTEN-FREE DIET: You followed a strict 100% gluten-free (gluten-ZERO) diet for 6+ months. (This means: you ask for a new salad if it comes topped with croutons [you don't simply pick the croutons off], you completely avoid pizza [you don't just remove toppings from a pizza and eat those and not the crust], you do not get the regular or "low" gluten communion wafer at your church, you never drink regular beer, you don't have a small bite of bread while at a restaurant or on vacation, etc)
		DAIRY-FREE DIET: You avoided all forms of dairy for 6+ months. (This means: you did not consume ANY dairy including butter, ghee, whey protein powder, cheese, cream (i.e. coffee creamer), ice cream, cream cheese, cottage cheese, etc).
		EGG-FREE DIET: You removed eggs from your diet for 30 days+.
		NIGHTSHADE-FREE DIET: You removed nightshades (potatoes, tomatoes, red peppers, etc) for 30+ days
		SOY-FREE DIET: You removed soy from your diet for 30+ days
		VEGETARIAN DIET: You avoided most animal-based proteins (but still included some animal products like eggs or seafood).
		VEGAN DIET: You avoided ALL animal products.

		RAW FOOD DIET: All or most of your diet is raw/uncooked.
		LOW-CARB DIET: You restricted the amount of carbohydrates in your diet.
		KETOGENIC DIET: You restricted the amount of carbohydrates in your diet and ate high amounts of fat.
		LOW-FAT DIET: You restricted the amount of fat in your diet.
		LOW-SODIUM DIET: You restricted the amount of salt in your diet (or consume little to no salt).
		SUGAR-FREE DIET: You used artificial sweeteners instead of sugar and consumed “sugar-free” or “diet” products (i.e. Splenda/NutraSweet packets in your coffee or tea, sugar-free gum, diet soda, etc).
		INTERMITTANT FASTING: You frequently skip meals or go for long periods of time without eating.

Please fill out a food diary of everything you ate during the last two days
(or what you *typically* eat - if the last two days were not how you normally eat)
[please be specific - things like sandwich, vegetables, fruit, chips, and protein are too vague - we want to know more details, like “turkey sandwich on GF bread with lettuce, tomato, and mayo” or banana, strawberries, corn chips, spinach, broccoli, etc.]

DAY 1		DAY 2
BREAKFAST		**BREAKFAST**
MID-MORNING SNACK		**MID-MORNING SNACK**
LUNCH		**LUNCH**
MID-AFTERNOON SNACK		**MID-AFTERNOON SNACK**
DINNER		**DINNER**
MID-EVENING SNACK		**MID-EVENING SNACK**
BEFORE BED SNACK		**BEFORE BED SNACK**

TRAINING ANALYSIS (IF REQUIRED)

The following section is a record of your training. Please give an accurate list of what training you do on what days and include approximate times when training takes place.

Please be detailed!

I hereby state that all information provided is to be true, to my knowledge.

INITIAL:____________________________________

Lisa Pitel-Killah, FDN-P, AFDNP, HTMAP
Functional Medicine Consent to Treatment & Doctor Notification

Your FDN-Practitioner focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve wellness. As a Certified Functional Diagnostic Nutrition Practitioner and Hair Tissue Mineral Analysis Practitioner, Lisa Pitel-Killah educates and motivates clients to assume more personal responsibility for their health by adopting a healthy attitude, lifestyle, and diet. While people generally experience greater health and wellness as a result of embracing these lifestyle pillars, your FDN-Practitioner cannot guarantee protection from future illnesses.

Laboratory testing is an intricate part of building the client's path to customized wellness and any out of reference range laboratory test results will be indicated and discussed by your FDN-Practitioner. However, it is your responsibility to deliver all laboratory test results, now and in the future, to your own Physician for any medical interpretation or opinion. As an FDN-Practitioner, Lisa does not diagnose, cure or treat any illness or specific disease. FDN-Practitioners build up health in a holistic

fashion with natural supplements and protocols.

The undersigned agrees that he or she will receive a nutritional interpretation of the test results by Lisa Pitel-Killah that is to be used exclusively by the undersigned as an educational tool for personal health purposes. However, the personal Physician of the undersigned may use these same laboratory results to diagnose and treat disease. Before making any changes to the exercise, diet, and nutritional or hormonal supplementation, a physician should be consulted.

Lisa Pitel-Killah is not a Physician or Psychologist, and the scope of her consultation services does not include treatment or diagnosis of specific illnesses, diseases or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physician without delay. Only a licensed Physician can prescribe prescription drugs. Any mention of drugs in the course of consultation is only for the purpose of providing a complete history of drugs that the client is taking and not for the Practitioner to judge the appropriateness of the medication. Any change in prescription or dosage is the decision the client makes with his or her Physician. Additionally, you agree to disclose a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

Refund Policy, should tests be issued:
If you make a mistake collecting saliva, urine or stool specimens, etc., or if the lab refuses to accept specimens because of a mistake you made, a free replacement test kit will be provided to you. Please call the office before discarding any specimens collected. Otherwise, once test kits are in your possession, they may not be returned and no refunds are allowed for any test kits due to safety, hygiene and accuracy concerns.

____

PRINT NAME

____

SIGNATURE

____

DATE