CARBONE CHIROPRACTIC CENTER
FUNCTIONAL MEDICINE QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a therapeutic plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Email Address:_____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Referred by: _____ Height: ___' ____ " Weight: _____ Sex: _____

Today's Date _____ Cell Phone: (_____) _____-_____

Complaints/Concerns:
What do you hope to achieve in your consultation with us?

_____

_____

When was the last time you felt well?

_____

_____

Did something trigger your change in health?

_____

_____

What makes you feel worse?

_____
_____

What makes you feel better?

_____
_____

Background Information:

1. Please check appropriate box(es):

☐ African American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

2. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister

_____
_____
_____

3. Do you have any pets or farm animals? Yes____ No____
If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

4. Have you lived or traveled outside of the United States? Yes____ No____
If so, when and where? _____
_____

5. Have you or your family recently experienced any major life changes? Yes____ No____
If yes, please comment: _____
_____

6. Have you experienced any major losses in life? Yes____ No____
If so, please comment: _____
_____

7. How important is religion (or spirituality) for you and your family's life?
a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

8. How much time have you lost from work or school in the past year?
a. _____ 0-2 days
b. _____ 3 –14 days
c. _____ > 15 days

9. Previous jobs:
_____

10. Are you currently, or have you ever been, married? Yes____ No____

If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

11. Hobbies and leisure activities (what makes your soul sing?)
_____
_____

12. Do you have mercury amalgam fillings? Yes____ No____

13. Do you live or work in a large metropolitan city that often has smog or heavy air pollution?

Yes____ No____

14. Are you frequently exposed to household or lawn/garden chemicals? Yes____ No____

15. Do you have regular contact with or exposure to commercial solvents (artist's supplies, dry cleaning solvents or petroleum based products) Yes____ No____

16. Foreign Travel? Yes____ No____
Where? _____

17. Do you have any artificial joints or implants? Yes____ No____

18. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _____spring _____fall
_____summer _____winter

19. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? _____lead _____cadmium _____ aluminum
_____arsenic _____mercury

20. Do odors affect you? Yes____ No____

21. Are you currently taking any medications or supplements? If so, what kind and how often?
_____
_____
_____
_____

22. Are you allergic to any medications? Yes____ No____
If yes, please list: _____
_____

23. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

24. As a child, were there any foods that you had to avoid because they gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea) _____

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25. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

26. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

27. Do you feel much **worse** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

28. Do you feel much **better** when you eat a lot of :

_____high fat foods	_____refined sugar (junk food)
_____high protein foods	_____fried foods
_____high carbohydrate foods (breads, pastas, potatoes)	_____1 or 2 alcoholic drinks
	_____other _____

29. Does skipping a meal greatly affect your symptoms? Yes____ No____

30. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____
If yes, what food(s)? _____
_____

31. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

32. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

33. Intestinal gas:
_____Daily _____ Present with pain
_____Occasionally _____ Foul smelling
_____Excessive _____ Little odor

34. Do you feel that you experience a great deal of stress on most days, regardless of how you manage stress? Yes____ No____

35. Bedtime_____ Morning Rise Time_____
36. Do you sleep through the night?_____
37. Do you wake up feeling rested? _____
38. Daily stress level: low_____ moderate_____ high_____
39. Do you exercise regularly? _____ If yes, how many times/week _____ for how long (minutes) _____?
40. Type of exercise_____

41. How many ounces of water do you drink/day (1cup=8oz)?_____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from _____ to _____
What kind? _____
Comments: _____

Medical History

□ Arthritis
□ Allergies/Hay Fever
□ Asthma
□ Alcoholism
□ Alzheimer's Disease
□ Autoimmune Disease
□ Blood Pressure Problems
□ Bronchitis
□ Cancer
□ Chronic Fatigue Syndrome
□ Carpal Tunnel Syndrome
□ Cholesterol, Elevated
□ Circulatory Problems
□ Colitis
□ Dental Problems
□ Depression
□ Diabetes
□ Diverticular Disease
□ Drug Addiction
□ Eating Disorder
□ Epilepsy
□ Emphysema
□ Eyes, Ears, Nose, Throat problems
□ Environmental Sensitivities
□ Fibromyalgia
□ Gastroesophageal Reflux Disease
□ Genetic Disorder
□ Glaucoma
□ Gout
□ Heart Disease
□ Infection, Chronic
□ Stroke
□ Thyroid Trouble
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually Transmitted Disease
□ Skin Problems
□ Tuberculosis
□ Ulcer
□ Urinary Tract Infection
□ Varicose Veins

Other _____
_____

Medical (Men)

□ Benign Prostatic
□ Prostate Cancer
□ Decreased Sex Drive
□ Infertility
□ Sexually Transmitted Disease

Other _____
_____

Medical (Women)

□ Menstrual Irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic Breasts
□ Fibroids/ Ovarian Cysts
□ Premenstrual Syndrome (PMS)
□ Breast Cancer
□ Pelvic Inflammatory Disease
□ Vaginal Infections

Age of first period _____
Date- Last Menstrual Cycle ___
Length of cycle _____ days
Interval of time between cycles _____ days
Any recent changes in normal menstrual flow (e.g. heavier, clots, scanty) _____
□ Surgical Menopause
□ Menopause

Family Health History

(Parents and Siblings)

□ Arthritis
□ Asthma
□ Alcoholism
□ Alzheimer's Disease
□ Cancer
□ Depression
□ Diabetes
□ Drug Addiction
□ Eating Disorder
□ Genetic Disorder
□ Heart Disease
□ Mental Illness
□ Mental Retardation
□ Migraine Headaches
□ Neurological Disorders (Parkinson's, Paralysis)
□ Obesity
□ Osteoporosis
□ Stroke
□ Suicide
Other _____

□ Inflammatory Bowel Syndrome

□ Irritable Bowel Syndrome

□ Kidney or Bladder Disease

□ Learning Disabilities

□ Liver or Gallbladder Disease

□ Mental Illness

□ Migraine Headaches

□ Neurological Problems, (Parkinson's, paralysis)

□ Sinus Problems

□ Decreased Sex Drive

□ Sexually Transmitted Disease

Other _____

_____

Date of last GYN exam _____

Mammogram □ + □ -

PAP □ + □ -

Form of Birth Control _____

# of Children _____

# of Pregnancies _____

□ C- Section

Health Habits

□ Tobacco
Cigarettes: #/day_____
Cigars: #/day _____

□ Alcohol
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____

□ Caffeine:
Coffee: #6 oz cups/day _____