WHAT TO EXPECT

FUNCTIONAL MEDICINE

- Functional medicine is a holistic approach to health in which practitioners attempt to uncover the root cause of symptoms through functional medicine testing and treat problems through natural means.
- Functional medicine is typically not covered under most commercial insurance plans.
- Functional medicine is a long-term investment in your health and focuses on optimizing quality of life.

THE FIRST APPOINTMENT

- Spend roughly 1 hour with Provider reviewing paperwork along with initial exam
- Review financials with Health Coach
- Purchase recommended test kits

THROUGHOUT THE TREATMENT PHASE

- Meet with Health Coach after 1st week. Review binder, ask questions, set goals.
- Meet with Provider & HC once a month to discuss progress, lifestyle changes, concerns and any results.
- Modifying how you eat and live is an essential part of our program.
    - To some degree, your lifestyle up to now has led you to the state of health you are currently in.
    - We will almost always instruct our patients to be 100% gluten free, dairy free, and gravitate towards a whole food nutrition plan, focusing on meats, vegetables, and fruits.
    - There will be recommendations for daily supplements to replenish deficiencies, bridge nutritional gaps, and help your body rid harmful toxins.

THE LONG-TERM FUTURE

- Be an active part of the team – You are your best advocate!! Ask questions, contact us if you think something is not right or you do not know if what you are experiencing is normal. Be engaged in the recommendations you will need to implement at home.
- The time frame largely depends on how long you have been unwell and how quickly you embrace and implement healthy lifestyle changes. We cannot make lifestyle changes for you or stay consistent with supplements for you. What we can do is help to guide and support you on your journey.
- Set up meetings with Health Coach to help make lasting lifestyle changes, setting short and long term goals for your own health.
- For most patients, the first 6 months will end with the following:
    - A fresh set of bloodwork to verify progress
    - A recommendation for a 4-week detox plan
    - A maintenance supplement and lifestyle plan
- Patients who have been sick for a very long time may not progress rapidly enough to be ready for detox and maintenance at the 6-month mark. These patients will be handled on an individualized basis, and we will continue to work with and support them until their body is ready for those steps.
- Patients who complete the program will be armed with sufficient information to move forward in a way that maintains their newly found health.

OUR COMMITMENT TO YOU

- We love contributing to a healthy lifestyle! We will provide resources to educate you on how to eat and live so you and your family can enjoy a high quality of life. We will be available to answer your questions and address your concerns as you move towards a lifetime of good health.

Are you ready to join us in a journey to better health?

Functional Medicine Patient Timeline

Appt 1: New patient appointment - $250.00 paid at the time of scheduling
- 1-hour appointment with Provider and HC (not all time will be face-to-face with staff)
- Review paperwork and discuss symptoms and treatment goals
- Determine necessary testing, which may include additional test kits ($750-$2500.00)
- Schedule a blood draw and a chiropractic adjustment for a future date

Appt 2: FASTING Blood Draw (part of initial package)

Patient homework: Complete recommended test kits at home
- Processing of tests results may take 4-6 weeks

Appt 3: Results discussion with Provider and HC (part of initial package)
- Review test results with copy provided, discuss lifestyle changes, review, and purchase recommended supplements ($350-$500.00 per month for the first 3 months)

Appt 4: Follow up with HC about one week after results discussion ($55.00)
- Review lifestyle changes and supplements, address questions and concerns, set goals.

Appt 5: Follow up with Provider and HC 3-4 weeks after appt 4 ($90.00)
- Review progress and discuss ongoing lifestyle changes

Appt 6: Follow up with Provider and HC 3-4 weeks after appt 5 ($90.00)
- Review progress and discuss ongoing lifestyle changes

Patient homework: See emailed progress questionnaire prior to blood draw and return to HC

Appt 7: FASTING Blood Draw ($25.00), additional testing may also be required ($25-$700.00)

Appt 8: Results discussion with Provider and HC ($90.00)
- Review newest test results, discuss, and tune lifestyle changes, if necessary, review and purchase updated recommended supplements ($250-$450.00 per month for an additional 3 months)

Appt 9: Follow-up with Provider and HC 3-4 weeks later ($90.00)
- Review progress and discuss ongoing lifestyle changes

Appt 10: Follow-up with Provider and HC 3-4 weeks later ($90.00)
- Review progress and discuss ongoing lifestyle changes

Patient homework: See emailed progress questionnaire prior to blood draw and return to HC

Appt 11: FASTING Blood Draw ($25.00), additional testing if required ($25-$700.00)

Appt 12: Results discussion with Provider and HC ($90.00)
- Review latest test results with copy provided, discuss progress, address questions and concerns
- Initiate detox protocol and discuss maintenance plan (or further testing/treatment if necessary)
- Detox protocol estimated at about $600.00. Maintenance/further treatment costs vary per patient.

Total investment: $4,000-$8,000 over the course of 7 months. Maintenance supplements and blood tests every 6 months or so. Some patients may require a longer course of treatment before initiating maintenance.

Financial Policy

Thank you for choosing Sycamore Chiropractic and Nutrition, LLC. We are committed to providing the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship. Please read this carefully and if you have questions, please do not hesitate to ask a member of our team. We require a signature to document that you have read and understand these policies.

INSURANCE

- We must emphasize that as providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.
- A current insurance card must be presented at check in for every visit. If the insurance company that you designate is incorrect, you will be responsible for payment.
- We will not bill another insurance carrier supplied later if it is past the timely filing period for that insurance company. If you are insured by more than one insurance company, our office needs to have all insurance policies on file.
- According to your insurance plan, you are responsible for all co-payments, deductibles, and coinsurances. When we verify that your deductible has not been met, we will collect up to our contracted rate with your insurance company at the time of service. Any amount due after your insurance company processes the claim and notifies Sycamore Chiropractic and Nutrition, LLC will be billed directly to you.
- Co-Payments are due at time of service. Co-payments are a contractual obligation between you and your insurance company. If multiple family members are being seen, they will have a separate charge and co-payment collected as required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, Sycamore Chiropractic and Nutrition will allow you to pay out of pocket at a discounted rate. That amount is due at the time of service.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referrals or authorization for specialty care, lab tests and other services that may be required. Please note physicians follow accepted national guidelines when determining your charges. They must code based upon what services were provided and cannot consider health plan benefits.

BILLING

- We will provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa, Discover, American Express and Apple Pay.

- We will charge your account a $35 non-sufficient funds charge if your check is returned to us for insufficient funds.
- We appreciate the difficulties involved in divorce and court orders. Sycamore Chiropractic and Nutrition will not participate in disputes between custodial and noncustodial parents regarding our patients who are minors. We will refer to the responsible party as the person who signs the financial policy, for reimbursement of any amounts due.
- Balances are due within 30 days of the first statement unless prior arrangements have been made with the billing department. Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- Staff will be collecting payments at check in on all accounts with balances that are more than 30 days past due. If you are having difficulty paying your bill, please discuss the situation with one of the members of our team.
- Should your account remain outstanding more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to an outside collection agency.
- **Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect that debt. We will make every attempt to set up payment arrangements with families that are going through a financial hardship. If we must refer your account to a collection agency, you may be charged additionally for any collection agency costs incurred. If we must refer collection of the account to an attorney, you may be charged additionally for any attorney fees we incur, including court costs. Please note that if your account is referred to a collection agency or an attorney for collection, the physicians of Sycamore Chiropractic and Nutrition may no longer be able to provide care for you and/or your family. In this case the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

MISSED APPOINTMENTS

- Please notify us as soon as possible if you need to cancel an appointment as someone else may want the time slot reserved for you. **A charge will be billed to your account for missed appointments not cancelled 24 hours in advance.** The charge will be based on the type of appointment and the amount of time allotted for the appointment, **and could be as much as $75,** and will be charged per patient scheduled. We will attempt to notify you of an appointment within 24 hours of your scheduled visit, but ultimately, it is your responsibility to call us to cancel if you cannot keep your scheduled time. Should missed appointments become habitual, the physicians at Sycamore Chiropractic and Nutrition may choose to no longer care for you and/or your family. In that case, the guarantor of the account will be notified by certified mail and will be given adequate time (30 days) to find a new provider.

OTHER

- **Forms and letters:** We are happy to fill out any necessary forms required by outside entities. Please contact the office for instructions or feel free to drop the form(s) off to one of our team members at the office. There will be a $30.00 charge for forms filled out, payable at the time the form is picked up. We ask that you allow 48 hours for the completion of all forms that are presented to Sycamore Chiropractic and Nutrition, LLC.
- **Records:** The charge for record transfer will be made per child in accordance will State of Ohio Records. Please ask at the time you request your records. There is no charge for records faxed to specialists. **All account balances will be collected before records are transferred.**
- **Functional Medicine Patients:** The fee for a two-hour new-patient appointment is $250.00, to be paid at the time of scheduling the appointment. The new patient appointment may be rescheduled one time at no cost. If you choose to cancel your appointment and not seek services, $50.00 is non-refundable.

FINANCIAL AGREEMENT

We appreciate your compliance with these policies. We strive to provide excellent, cost-effective care in anever-changing health care environment. We are happy to discuss any questions you have about these policies.

The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service. I certify that the information I have given to Sycamore Chiropractic and Nutrition, LLC is accurate. I hereby authorize Sycamore Chiropractic and Nutrition to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Sycamore Chiropractic and Nutrition all benefits for service rendered.

I have read and understand the Financial Policy from Sycamore Chiropractic and Nutrition. I agree to adhere to the above written policies, and all questions have been answered.

Patient Name (Please Print)

Patient Signature

Date

Sycamore Chiropractic and Nutrition
Designated Privacy Official: 513-773-1214

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Sycamore Chiropractic and Nutrition's Notice of Privacy Practices effective September 21, 2020.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restriction.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ Yes ☐ No

May we leave a message on your answering machine or on your cell phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family? ☐ Yes ☐ No

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature:_____ Date: _____

Witness:_____ Date: _____

Informed Consent to Treat

Thank you for trusting Sycamore Chiropractic and Nutrition with your health! We provide functional medicine counseling, nutritional counseling, chiropractic care, and massage therapy. Because you have chosen to engage one or more of these modalities, we ask you to sign this consent form:

I hereby request and consent to the performance of nutritional therapy and counseling, chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy (including but not limited to massage therapy, muscle stimulation, ultrasound, and stretching), and diagnostic X-rays on me and my family members (or on the patient named below for whom I am legally responsible) by Dr. David Boynton, DC, CCEP, or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss my health care needs and the nature and purpose of chiropractic adjustments and other procedures and counseling with Dr. Boynton, DC, CCEP and/or with other office or clinic personnel. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely upon the doctor to exercise judgment, based upon the facts then known to him or her, in providing treatment which the doctor feels is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I agree if I am pregnant or trying to get pregnant that I will inform the doctor immediately.

_____ _____

Patient Printed Name Date

_____

Consent to treat a Minor

I_____(☐ Mother, ☐ Father, ☐ Guardian) give permission to Sycamore Chiropractic and Nutrition to treat my son or daughter or legal dependent. I understand that I do not have to be present with them for every visit.

I understand that I am responsible for all charges that are associated with treatment of the minor for whom I am responsible.

_____ _____

Signature of Parent/Guardian Date

Instructions for filling out the functional medicine intake form

Thank you for choosing us to assist you in your journey to better health! Our ability to help you depends largely on the completeness and accuracy of information you provide in this form. Please include even symptoms that you consider minor so that we may have a complete picture of your health. We would like to remind you that all of this information is strictly confidential unless you state otherwise.

- It may take 1-3 hours to fill this form out in its entirety.
- Please download the form to your computer before filling it out. **If you fill it out in a web browser, the information you put in will not be saved.**
- Once you have finished filling it out, please email it to info@sycamorechiro.com.
- Our functional medicine staff will then reach out to you to schedule your appointment and collect the $250 fee that is due at the time of scheduling.

If you have any questions, please call the office or send an email to info@sycamorechiro.com
We look forward to serving you!

Functional Medicine Intake Form

Patient's Name: _____

How did you hear about our office? _____

Today's Date: _____ Date of Birth:____/____/_____Age:_____ Gender: ☐ M ☐ F

Address: _____

City:_____State:_____Zip Code: _____

Marital status:_____Cell Phone:_____Home Phone: _____

Email: _____

Job Title:_____Hours per week: _____

Nature of Business: _____

Genetic Background: Place a check mark next to your selection(s).

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean

☐ Native American ☐ Northern European ☐ Other: _____

Primary language spoken at home: ☐ English ☐ Spanish ☐ Other: _____

Emergency Contact

Name:_____Relationship:_____Telephone:_____

Insurance Information

Policy holder's name _____ Policy holder's date of birth _____

Member ID _____ Group ID _____

Relationship of patient to policy holder _____

Person filling out this form:_____Relationship to patient: _____

Is email a reliable way to communicate with you (the patient)? ☐ Yes ☐ No

Story Page

Name: **Age:** **Gender:** **Date:**

Please tell us your story about your health on this page.

Current Complaints and Concerns

List in a few words the main problems you are having or the purpose for your consultation (fatigue, anxiety, poor exercise tolerance, infertility, thyroid disorder, etc.):

1. _____

2. _____

3. _____

4. _____

Please rate your overall health from 0-10 with 0 being very poor and 10 being excellent:_____

Please rate your energy levels from 0-10 with 0 being very poor and 10 being excellent: _____

What do you most hope to accomplish by working with us?

_____

How long ago did your symptoms begin? _____

When was the last time you felt well? _____

Did something trigger a change in your health/symptoms? _____

_____

How much time have you lost from work/school in the past year due to health problems? _____

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
EX: *Headache*	*May 2006*	*2 times per week*	*Acupuncture, Aspirin*	*Mild improvement*

What diagnosis or explanations, if any, have you been given for these concerns?

What health care provider(s) have you seen for these conditions?

What types of treatments have you received for your symptoms and have they been helpful?

What seems to make you feel worse?

What seems to make you feel better?

Are you currently in pain? ☐ Yes ☐ No

Is the source of your pain due to an injury? ☐ Yes ☐ No

If yes, please describe the injury and the date it occurred:

If no, please describe how long you have had this pain and what you believe it is caused by:

Please list all of the areas where you currently have pain

Be as specific as possible with the location (upper, lower, right, left, inner, outer, generalized, etc.), type of pain (aching, sharp, dull, burning, tingling, etc.), and severity (mild, moderate, or severe).

Location:_____Type:_____Severity: _____

Location:_____Type:_____Severity: _____

Location:_____Type:_____Severity: _____

Location:_____Type:_____Severity: _____

Location:_____Type:_____Severity: _____

Medical History

Blood Type: ☐ A- ☐ A+ ☐ B- ☐ B+ ☐ AB- ☐ AB+ ☐ O- ☐ O+ ☐ Unknown

Height (feet/inches):_____ Current weight:_____ Desired weight: _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Childhood History

Were you a full-term baby? ☐ Yes ☐ No If born premature, how many weeks? _____

Were you born naturally or via C-section? ☐ Naturally ☐ C-section

Were you breast-fed? ☐ Yes ☐ No If yes, for how long? _____

When pregnant with you, did your mother: ☐ Smoke ☐ Use drugs ☐ Drink Alcohol ☐ Other

Where did you grow up (town name, general area – farmland, city, near major manufacturing, etc.)?

_____

Are you aware of specific toxins you were exposed to as a child? _____

Would you describe your childhood as safe, happy, and healthy? ☐ Yes ☐ No

Were you vaccinated as a child? ☐ Yes ☐ Partially ☐ No Age stopped vaccines: _____

Was your childhood diet high in sugar / soda / junk food? ☐ Yes ☐ No

As a child, were there foods that you had to avoid because they gave you symptoms? ☐ Yes ☐ No

If yes, please explain: _____

Childhood Illnesses

	No	Yes	Age		No	Yes	Age
ADD (Attention Deficit Disorder)	☐	☐		Hyperactivity	☐	☐	
Asthma or Croup	☐	☐		Seasonal Allergies	☐	☐	
Chicken Pox	☐	☐		Skin Disorders	☐	☐	
Colic	☐	☐		Strep Infections	☐	☐	
Congenital Problems	☐	☐		Tonsillitis	☐	☐	
Ear Infections	☐	☐		Upset Stomach, Digestive Problems	☐	☐	
Frequent Colds or Flu	☐	☐		Whooping Cough	☐	☐	
Frequent Headaches	☐	☐		Other (specify) _____	☐	☐	

Did you have any viruses (mono, hand/foot/mouth, etc.)? _____

Family Medical History

Examples to list in the table below

Thyroid problems	Alzheimer's or Dementia	Celiac Disease	Mental illness (specify)
Diabetes	Drug abuse	Emphysema	Stroke
Heart disease	Seizures / Epilepsy	Environmental sensitivity	Skin disorders
High blood pressure	Crohn's Disease	Genetic disorders	Glaucoma
High cholesterol	Autism	Autoimmune conditions	Bleeding tendency
Cancer (specify type)	ADD / ADHD	Kidney Disease	Asthma
Depression or Anxiety	Arthritis (type)	Liver Disease	Other (specify)

List any illnesses for each family member, suggestions below. If deceased, give cause of death and age at death.

Family Member	**Age**	**Alive**	**Dead**	**Illnesses / Cause of Death**
Paternal Grandfather		☐	☐	
Paternal Grandmother		☐	☐	
Maternal Grandfather		☐	☐	
Maternal Grandmother		☐	☐	
Father		☐	☐	
Mother		☐	☐	
Brother(s)		☐	☐	
Sister(s)		☐	☐	
Child(ren)		☐	☐	

Patient History

Accidents or Major Trauma/Injuries (list month and year) ☐ None

Surgeries/Hospitalizations (list month and year and reason) ☐ None

Ever had a cosmetic surgery (specify)? _____

Gastrointestinal

Never	Past	Now	
			Irritable Bowel Syndrome
			Inflammatory Bowel Disease
			Crohn's or Ulcerative Colitis
			Gastritis or Peptic Ulcer Disease
			GERD (reflux) or Hiatal Hernia
			Celiac Disease
			Gallstones
			Intestinal Worms or Parasites
			Other

Neurologic / Mood

Never	Past	Now	
			Depression
			Anxiety
			Bipolar Disorder
			Schizophrenia
			Headaches
			Migraines
			ADD / ADHD
			Autism
			Parkinson's Disease
			Multiple Sclerosis
			Seizures or Convulsions
			Alzheimer's
			Concussion / Whiplash
			Other

Genital & Urinary

Never	Past	Now	
			Kidney Disease or Infections
			Kidney Stones
			Gout
			Interstitial Cystitis
			Frequent UTI / Bladder Infections
			Frequent Yeast Infections
			Other

Metabolic/Endocrine

Never	Past	Now	
			Type 1 Diabetes
			Type 2 Diabetes
			Hypoglycemia (low blood sugar)
			Insulin Resistance or Pre-Diabetes
			Hypothyroidism (low thyroid)
			Hyperthyroidism (high thyroid)
			Hashimoto's or Grave's Disease
			Polycystic Ovarian Syndrome
			Infertility
			Weight Gain
			Weight Loss
			Anorexia or Bulimia
			Binge Eating Disorder
			Night Eating Disorder
			Other

Cardiovascular

Never	Past	Now	
			Heart Attack
			Heart Disease
			Stroke
			Elevated Cholesterol
			Arrhythmia (irregular heartbeat)
			Hypertension (high blood pressure)
			Rheumatic Fever
			Mitral Valve Prolapse
			Other

Respiratory

Never	Past	Now	
			Asthma
			Bronchitis
			Emphysema
			Pneumonia
			Sleep apnea
			Other

Never	Past	Now	Skin Disease
☐	☐	☐	Eczema
☐	☐	☐	Psoriasis
☐	☐	☐	Acne
☐	☐	☐	Melanoma
☐	☐	☐	Rashes that don't go away Locations:
☐	☐	☐	Other

Never	Past	Now	Miscellaneous
☐	☐	☐	Anemia
☐	☐	☐	Mononucleosis
☐	☐	☐	Scarlet Fever
☐	☐	☐	Malaria
☐	☐	☐	Venereal Disease
☐	☐	☐	Covid-19
☐	☐	☐	Other

Never	Past	Now	Musculoskeletal
☐	☐	☐	Osteoarthritis or Arthritis
☐	☐	☐	Fibromyalgia
☐	☐	☐	Chronic Pain
☐	☐	☐	Other

Any history of cancer? ☐ Yes ☐ No

Type:_____

Date diagnosed: _____

Current status:_____

Medications and Supplements

Please list all prescription and over the counter medications you are currently taking

Medication	Dose	Frequency	Length of time on it	Reason for taking it
Ex: Ibuprofen	*400 mg*	*2 X a day*	*1 week*	*Knee injury*

Please list all supplements (vitamins, minerals, meal replacements) you currently take.

Supplement	Brand	Form	Dose/Frequency	Length of Time
Ex: Vitamin D	*NOW Foods*	*Soft gel cap*	*5000 IU / 1 x daily*	*6 months*

Are you allergic to any medications (list)? _____

Symptom Questionnaire

Check mark any that apply to you

General Health

- ☐ Always thirsty
- ☐ Always hungry
- ☐ Often fatigued or exhausted
- ☐ Worn out by little effort
- ☐ Considered sickly or in poor health
- ☐ General weakness / muscle weakness
- ☐ Balance problems / considered clumsy
- ☐ Handwriting is getting less legible
- ☐ Hands tremble slightly for no reason
- ☐ Cold hands and feet
- ☐ Excessive sweating
- ☐ Difficulty sweating

Musculoskeletal

- ☐ Numbness or tingling anywhere
- ☐ Injure, sprain, or strain easily
- ☐ Joint swelling, pain, or stiffness
- ☐ Restless legs
- ☐ Difficulty bending or reaching
- ☐ Morning stiffness
- ☐ Back pain
- ☐ Damp weather bothers you
- ☐ Muscle cramps or spasms
- ☐ Aching muscles not due to exercise

Ears, Nose, Throat

- ☐ Swollen neck glands
- ☐ Neck lumps or goiter
- ☐ Sinus congestion / discharge
- ☐ Chronic sinusitis
- ☐ Post-nasal drip, frequent throat clearing
- ☐ Difficulty swallowing food or pills
- ☐ Had tonsils removed
- ☐ Excessive mucus
- ☐ Frequent hoarseness
- ☐ Poor sense of smell / taste
- ☐ Seasonal allergies
- ☐ Prone to snoring
- ☐ Nosebleeds
- ☐ Sensitive to odors / fragrances
- ☐ Ear aches / pains / pressure
- ☐ Ringing in the ears
- ☐ Hearing loss
- ☐ Ear discharge or itching
- ☐ Frequent ear infections
- ☐ Sensitive to loud noises

Kidneys, Urinary Tract

- ☐ Burning or pain when urinating
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Strong smelling urine
- ☐ Difficulty passing urine (weak flow)
- ☐ Kidney pain (lower back aching)
- ☐ Incontinence (poor bladder control)
- ☐ Bedwetting

Head, Brain, Eyes

- ☐ Poor concentration / focus
- ☐ Mental sluggishness / brain fog
- ☐ Forgetfulness / poor memory
- ☐ Dizziness
- ☐ Hair loss or dry/brittle
- ☐ Thinning eyebrows
- ☐ Headaches
- ☐ Irritated by strong lights
- ☐ Eye pain or pressure
- ☐ Dry or itchy eyes
- ☐ Eyes red, inflamed, or puffy
- ☐ Blurred or double vision
- ☐ Floaters or flashers in vision
- ☐ Difficulty driving at night
- ☐ Frequent or constant twitching
- ☐ Dark circles under eyes
- ☐ Visual hallucinations
- ☐ Watery eyes

Skin

- ☐ Bruise easily / bruises heal slowly
- ☐ Rashes, hives, frequent itching
- ☐ Eczema or Psoriasis
- ☐ Acne
- ☐ Dry, cracking, peeling skin
- ☐ Sensitive to fabrics, detergents, etc.
- ☐ Cellulite
- ☐ Bugs love to bit you
- ☐ Nails are weak, split, or have lines/spots
- ☐ Fungus on nails, Athlete's Foot
- ☐ Crawling sensation on skin
- ☐ Burning on bottom of feet

Teeth, Mouth

- ☐ Sore or bleeding gums (gingivitis)
- ☐ TMJ problems
- ☐ Tooth pain/aches
- ☐ Problems chewing
- ☐ Have or had braces
- ☐ Chronically dry mouth
- ☐ Sour or metallic taste
- ☐ Chronic bad breath (halitosis)
- ☐ Tongue coated
- ☐ Frequent canker sores or fever blisters
- ☐ Chapped lips (frequent Chapstick)
- ☐ Grind teeth when sleeping

Regular cleaning/care at a dentist? ☐ Yes ☐ No Floss regularly? ☐ Yes ☐ No

____ Number of cavities
____ Number of metal/mercury fillings
____ Number of root canals
____ Number of implants in your mouth

List any major dental work with your approximate age and any health problems following that work.

Gastrointestinal

Have you ever traveled out of the country? ☐ Yes ☐ No

If so, where and when? _____

Have you ever done wilderness camping? ☐ Yes ☐ No

If so, where and when? _____

Have you ever had severe gastroenteritis or diarrhea? ☐ Yes ☐ No

Have you taken antibiotics in the last year? ☐ Yes ☐ No If yes, how many times? _____

Have you ever taken antibiotics for more than two weeks at a time? ☐ Yes ☐ No

Have you ever had to take antibiotics more than once for a chronic ailment? ☐ Yes ☐ No

Have you frequently been on antibiotics, either as a child or as an adult? ☐ Yes ☐ No

Have you frequently taken NSAIDs (Ibuprofen, naproxen, etc.) as a child or as an adult? ☐ Yes ☐ No

Have you ever been on an acid-reducing medication (Nexium, Prilosec, Pepcid, etc.)? ☐ Yes ☐ No

How often do you have a bowel movement? ☐ 3+ daily ☐ 1-3 daily ☐ 4-6/week ☐ 1-3/week

Mark the following as they apply to your bowel movements:

☐ Medium brown ☐ Dark or black ☐ Greenish ☐ Visible blood ☐ Tan ☐ Color varies

☐ Soft / well-formed ☐ Loose ☐ Firm / hard to pass ☐ Often floats ☐ Consistency varies

Do you have intestinal gas? ☐ Occasionally ☐ Daily ☐ Excessive ☐ Foul-smell ☐ No odor

Mark any that apply to you:

☐ Poor appetite
☐ Excessive appetite
☐ Feel swollen around abdomen area
☐ Bloating/pain/cramping after eating
☐ Feel full after a small meal
☐ Feel hungry 1-2 hours after a large meal
☐ Digestion seems unusually rapid
☐ See undigested food in stool
☐ Frequent upset stomach, nausea
☐ Nervous stomach
☐ Indigestion, acid reflux, belching
☐ Burning in lower chest (esp. laying down)
☐ Abdominal pain, cramps, spasms
☐ Stomach pain relieved by eating, antacids
☐ Unable to totally empty bowels
☐ Dependent on laxatives
☐ Rectal itching or burning
☐ Rectal hemorrhoids (bleeding)
☐ Jaundice (yellow eyes and/or skin)
☐ Liver or gallbladder trouble
☐ Forehead pain after overeating
☐ Pain in back / right shoulder at night
☐ Significantly affected by odors such as fragrance, cigarettes, auto exhaust, perfumes

Circulatory, Respiratory

- ☐ Swollen ankles / feet
- ☐ Sensitive to heat / cold
- ☐ Arms or legs cold or clammy
- ☐ Hands/feet go to sleep or tingle
- ☐ Poor circulation
- ☐ High blood pressure
- ☐ Chest pain, heaviness, tightness
- ☐ Pain between shoulders
- ☐ Fainting spells
- ☐ Heart murmur
- ☐ Heart palpitations, pounding, racing
- ☐ Abnormal heart rhythm
- ☐ Night sweats
- ☐ Varicose veins / spider veins
- ☐ Low exercise tolerance
- ☐ Run out of breath easily
- ☐ Wheezing
- ☐ Frequent sighing / deep breaths
- ☐ Frequent coughing
- ☐ Frequent cold / respiratory infections

Endocrine, Hormones

Women

Currently pregnant? _____ History of hysterectomy? ☐ No ☐ Yes Date: _____

Number		Number		Number	
	Pregnancies		Abortion		Gestational Diabetes
	Caesarean Deliveries		Living Children		Post Partum Depression
	Vaginal Deliveries		Miscarriage		Breast Fed Babies

Age at first period? _____ Menses frequency? _____ Length? _____

Pain? ☐ Yes ☐ No Clotting? ☐ Yes ☐ No Last menstrual period? _____

Are you in menopause? ☐ Yes ☐ No Age at menopause: _____

Use of contraceptives? If so, what type and for how long? _____

Last PAP test: _____ ☐ Normal ☐ Abnormal

Symptoms/Conditions (mark the ones you have)

☐	Fibrocystic Breasts	☐	PMS	☐	Hot Flashes
☐	Endometriosis	☐	Vaginal Dryness	☐	Palpitations
☐	Fibroids	☐	Mood Swings	☐	Joint pains
☐	Infertility	☐	Decreased Libido	☐	Headaches
☐	Painful Periods	☐	Heavy Periods	☐	Loss of control of urine

Use of hormone replacement therapy? ☐ Yes ☐ No How long? _____

What type? _____

Sexually active? ☐ Yes ☐ No Ever had an STD (specify)? _____

Men

Last prostate specific antigen (PSA) level? _____ ☐ Unknown ☐ Never checked

☐ Prostate enlargement or infection
☐ Change in libido
☐ Impotence
☐ Difficulty obtaining/maintaining erection
☐ Genital pain
☐ Sexually transmitted disease
☐ Infertility
☐ Hernia / lumps in testicles
☐ Urinary urgency
☐ Hesitation when urinating
☐ Loss of control of urine
☐ Nocturia (night time urination)

Adrenal / HPA Axis

☐ Feel dizzy upon standing
☐ Difficulty making decisions / indecisive
☐ Low blood pressure
☐ Listless / groggy, chronic fatigue
☐ Reaction time is slow
☐ Emotional instability
☐ Blurry vision / poor visual focus
☐ Easily overwhelmed
☐ Feel worse if you don't eat often enough (hangry, dizzy, weak, shaky, nauseous, headache, etc.)

Emotional Health

Are you happy now?	☐ Yes	☐ No
Do you feel your life has meaning and purpose?	☐ Yes	☐ No
Do you like the work you do?	☐ Yes	☐ No
Do you believe stress is presently reducing the quality of your life?	☐ Yes	☐ No
Do you spend most of your time/money to fulfill responsibilities (workaholic)?	☐ Yes	☐ No
Do you spend most of your time alone or in your house without going out?	☐ Yes	☐ No

Check mark the ones that apply to you

☐ Frequently keyed up or jittery
☐ Startled by sudden noises
☐ Easily upset, irritated, or stressed
☐ Frequently anxious or worried
☐ Feel hostile or aggressive
☐ Tremble if someone shouts at you
☐ Become frightened for no reason
☐ Awakened by frightening dreams
☐ Blackouts / Amnesia
☐ Ever had a nervous breakdown
☐ Do things on sudden impulse
☐ Withdrawn feeling / feeling lost
☐ Feel alone or sad at a party
☐ Usually unhappy or depressed
☐ Cry frequently
☐ Life looks entirely hopeless
☐ Emotional numbness
☐ Unable to reason
☐ Difficulty working under pressure
☐ Hyperactive

Significant Events

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

Roles and Relationships

Do you have children (list ages/gender)? _____

Who is living in your household? _____

Employment/occupations of those living in your household: _____

Resources for emotional support? _____

☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other

Stress and Coping

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily stressors: Rate on a scale of 1—10. (1 = minimal stress. 10 = very high stress)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Have you ever sought counseling or psychiatric care? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

Do you practice mediation or relaxation techniques? ☐ Yes ☐ No

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Prayer ☐ Tai Chi ☐ Other

Hobbies and Leisure activities: Lack of interest in hobbies? ☐ Yes ☐ No

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How well have things been going for you?

	Very Well	Fine	Poorly	Does Not Apply
Overall	☐	☐	☐	☐
At school or in your job	☐	☐	☐	☐
In your social life	☐	☐	☐	☐
With your close friends	☐	☐	☐	☐
With your attitude	☐	☐	☐	☐
With your significant other	☐	☐	☐	☐
With your children	☐	☐	☐	☐
With your parents	☐	☐	☐	☐

Nutritional History

Do you grocery shop? ☐ Yes ☐ No *If no, who does?* _____

Do you cook? ☐ Yes ☐ No *If no, who does?* _____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Do you read food labels? ☐ Yes ☐ No

Check all the factors that apply to your current lifestyle and eating habits

☐	Erratic eating pattern	☐	I dislike healthy food
☐	Late night eating	☐	Family members dislike healthy foods
☐	Love to eat	☐	Family members have special diet needs/desires
☐	Eat because I have to	☐	Eat more than 50% of meals away from home
☐	Have a negative relationship with food	☐	Travel frequently
☐	Emotional eater (eat when sad, lonely, bored)	☐	Don't care to cook
☐	Eat too much under stress	☐	Do not plan meals or menus
☐	Eat too little under stress	☐	Reliance on convenience
☐	Confused about nutrition advice	☐	Poor snack choices
☐	Difficulty gaining weight	☐	Always hungry or thirsty
☐	Difficulty losing weight	☐	Rarely hungry or thirsty

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No

The most important thing I should change about my eating habits to improve my health is:

_____

Please list the foods that you normally consume at each meal

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you currently follow any particular diet or nutritional program? ☐ Yes ☐ No

☐ Gluten-Free ☐ Low-Carb ☐ Dairy-Free ☐ Vegetarian ☐ Vegan ☐ Blood Type

Other: _____

Do you avoid any particular foods (type and reason)? _____

If you could only eat a few foods a week, what would they be?

_____

What foods do you dislike? _____

What foods do you crave? _____

How many times do you chew your food? _____

How many servings of fruits and vegetables do you eat per day? _____

What oils do you cook with? _____

Do you eat dessert? If so, what do you eat? _____

Do you have snacks during the day? If so, what do you snack on?

What times do you normally eat?

Breakfast: _____ Lunch: _____ Dinner: _____ Snack: _____ _____ _____

Do you skip meals? ☐ No ☐ Occasionally ☐ Weekly ☐ Daily ☐ Intermittent Fasting

Do you eat while standing up? ☐ No ☐ Sometimes ☐ Often

What types of beverages do you consume? _____

Do you drink coffee? ☐ No ☐ 1 cup/day ☐ 2-4 cups/day ☐ >4 cups/day

Do you drink caffeinated tea? ☐ No ☐ 1 cup/day ☐ 2-4 cups/day ☐ >4 cups/day

Do you drink caffeinated sodas or diet sodas? ☐ No ☐ 12-24 oz / day ☐ >24 oz / day

List favorite type of soda (if any): _____

How much fluid do you drink with meals?_____How much water do you drink daily? _____

Do you have symptoms immediately after eating? ☐ Yes ☐ No

☐ Belching ☐ Bloating ☐ Drowsiness ☐ Gas ☐ Hives ☐ Sneezing ☐ Other

If yes, are these symptoms associated with any particular food or supplements? ☐ Yes ☐ No

If yes, please specify: _____

Do you feel that you have delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc.? Symptoms may not be evident for 24 hours or more. ☐ Yes ☐ No

Do you feel better or worse or no different if you eat the following foods?

High carb foods (breads, pasta, potatoes)_____Fried foods _____

High protein foods_____High fat foods _____

Refined sugar (junk food)_____Spicy foods _____

1-2 alcoholic drinks_____Citrus foods _____

Lifestyle History

Smoking, Alcohol, Drugs

Do you currently smoke? ☐ Yes ☐ No Did you used to smoke? ☐ Yes ☐ No

If yes, how many years?_____Packs per day? _____

Attempts to quit? _____

Do you use any other tobacco products (specify)? _____

Does anyone in your household smoke? ☐ Yes ☐ No

Are you frequently exposed to second hand smoke? ☐ Yes ☐ No

Rate your history of alcohol intake: ☐ None ☐ Mild ☐ Moderate ☐ High

How many drinks do you consume per week? (*1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*)

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 (If "none," skip to Other Substances below)

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (you can hold more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking alcohol? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Are you currently using any recreational drugs? ☐ Yes ☐ No Type: _____

Have you ever used recreational drugs? ☐ Yes ☐ No Type:_____

Do you have a prescription/card for medical marijuana? ☐ Yes ☐ No

Sleep and Rest

Average number of hours you sleep per night? ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

When do you normally go to bed? _____ When do you normally wake up? _____

☐ Trouble falling asleep

☐ Trouble staying asleep

☐ Often wake up between 1-3am

☐ Do not feel rested in the morning

☐ Need caffeine to really wake up

☐ Nightmares

☐ No dream recall

☐ Problems with snoring

☐ Use sleeping aids

☐ Need or want to sleep during the day

☐ Practice sleep hygiene

☐ Turn off the house WiFi at night

Exercise

Do you exercise regularly? ☐ Yes ☐ No

Do you have a sedentary job? ☐ Yes ☐ No

Describe current exercise habits (walking, weight training, yoga, sports, aerobics, etc.)

Rate your level of motivation for including exercise in your life: ☐ Low ☐ Medium ☐ High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

Do you usually sweat when exercising? ☐ Yes ☐ No

Environmental

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Radon ☐ Medical Radiation

How many hours a day do you spend on a cell phone?_____On a computer? _____

Do you notice any symptoms related to electronic device exposure? _____

Do you have a known history of significant exposure to any chemicals/pesticides? ☐ Yes ☐ No

Chemical Name, Date, Length of exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you have any pets or animals? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?

☐ No ☐ Past ☐ Current

Do you or have you ever lived or worked close to a power plant, busy highway, paper mill, steel factory, etc.?

☐ No ☐ Past ☐ Current If yes, please specify:_____For how long? _____

In what environment (home, work, nature, etc.) do you tend to feel best? _____

In what environment (home, work, nature, etc.) do you tend to feel worst? _____

Other comments about possible environmental exposures throughout the course of your life:

What brands of personal care products do you use? (Deodorant, lotions, soaps, make-up, etc.)

Readiness Assessment

In order to improve your health, how willing are you to:

	Very willing	Somewhat willing	Unsure	Not really willing	Not willing at all
Significantly modify your diet	☐	☐	☐	☐	☐
Take nutritional supplements each day	☐	☐	☐	☐	☐
Modify your lifestyle (work demands, sleep habits, etc.)	☐	☐	☐	☐	☐
Practice relaxation techniques	☐	☐	☐	☐	☐
Engage in regular exercise	☐	☐	☐	☐	☐
Have periodic lab tests to assess progress	☐	☐	☐	☐	☐

Please list any previous functional medicine testing you have had done. ☐ None

_____

How do you learn best? ☐ Visual / Video ☐ Audio ☐ Reading ☐ Discussion

Any other comments or concerns

End of Functional Medicine Intake Form

Thank you for taking the time to complete this health history medical questionnaire. The information derived from these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. We look forward to helping you achieve lifelong health and well-being!

Yours in Good Health,

Dr. David Boynton and the Sycamore Chiropractic and Nutrition Team