Integrative Health Inc
Experts Providing Healthcare

Functional Medicine Questionnaire

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

This questionnaire is in addition to the initial intake form (which must have been completed within the last two years).

Patient Contact Information

Name: _____ Date: _____

DOB _____ Age: ____ □ ☐ Male ☐ Female If minor, name of parent: _____

Cell #(_____)_____

Complete the information below if it has changed since completing the initial intake form:

Address:_____City:_____ State:____ Zip:_____

E-mail address: _____

Employer: _____ Occupation:_____

Married or have a life partner ☐ Yes ☐ No Significant other's name: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

2nd Contact: _____ Relationship: _____ Phone:_____

On a scale of 1-10, rate your commitment to getting rid of the problem(s) and feeling better: _____

What other services have you tried?

☐ Acupuncture
☐ Chiropractic
☐ Functional Medicine
☐ Massage
☐ Primary Care
☐ Other:_____

SUPPLEMENTS	PURPOSE	HOW LONG

Diet (check all that apply and write how much per day/week)

☐ Sugar/Candy: _____
☐ Cookies/Baked Goods: ___
☐ Reg./Diet Soda: _____
☐ Chocolate: _____
☐ Dairy/Milk: _____
☐ Cheese: _____
☐ Yogurt: _____
☐ Ice-Cream: _____
☐ White Flour/Bread: _____
☐ Pasta: _____
☐ Coffee: _____
☐ Alcohol: _____
☐ Protein 50g: _____
☐ Eggs: _____
☐ Dark greens: _____
☐ Fruits: _____
☐ Fast Food: _____
☐ Do you eat breakfast?_____