North Macon Wellness Therapy
Adult Comprehensive Functional Medicine Intake

Patient Information

Full Name: _____

Date of Birth:_____
Sex: ☐ M ☐ F ☐ Other ☐

Address:_____

Phone Number:_____

Email:_____

Occupation:_____

Marital Status:_____

Emergency Contact Name, Relationship & Phone:

_____

Reason for Visit

What are your main health concerns/goals for this visit?
(Include both physical and emotional/mental concerns.)

1.

2.

3.

When did these issues begin?

What have you tried so far?
☐ Medications
☐ Supplements
☐ Lifestyle changes
☐ Therapy
☐ Other: _____

How would you rate your current overall health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Healthcare Team

Primary Care Provider Name & Location:

Other Practitioners You See Regularly:
☐ Chiropractor
☐ Naturopath
☐ Therapist
☐ Specialist(s): _____

Medical History

Past Diagnoses or Conditions:
☐ Hypertension
☐ Diabetes
☐ Thyroid Disorder
☐ Autoimmune Disease
☐ Asthma/Allergies
☐ Depression/Anxiety
☐ Cancer (Type): _____
☐ Other: _____

Surgeries/Hospitalizations (with dates):

Major Injuries/Accidents (with dates):

Do you have a family history of any chronic illnesses?

☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ Autoimmune Disorders
☐ Mental Health Conditions
☐ Other: _____

Medications & Supplements

Current Medications (Rx or OTC):

Name	Dose	Frequency	Purpose

Current Supplements or Herbs:

Name	Dose	Frequency	Purpose

Medication Allergies/Sensitivities:

Food Allergies or Sensitivities:

Lifestyle & Environment

Sleep

- Hours per night: ___
- Quality: ☐ Good ☐ Fair ☐ Poor
- Trouble falling or staying asleep? ☐ Yes ☐ No

Diet

- How would you describe your typical diet?
- Do you follow a specific eating pattern (vegan, paleo, etc)?
- Number of meals per day: __
- Caffeine: ☐ Yes ☐ No — Amount/day: ___
- Alcohol: ☐ Yes ☐ No — Amount/week: ___
- Tobacco: ☐ Yes ☐ No — Type & Amount: ___
- Recreational drugs: ☐ Yes ☐ No — Type: ___

Exercise

- Type:
- Frequency: ___ days/week
- Duration per session: ___ minutes

Stress & Mental Health

- Stress level (1–10): ___
- Main stressors:
- Do you practice stress management (e.g., meditation, yoga)?
- Mental health history (anxiety, depression, PTSD, etc.):

Social & Emotional Support

- Do you feel supported by friends/family?
- Are you in a safe living situation?
- Any major recent life events?

Environment

- Do you have mold or chemical exposure at home/work?
- Pets in the home?
- Water source: ☐ Filtered ☐ Tap ☐ Well

Body Systems Review *(Check all that apply)*

Energy & Sleep

☐ Fatigue
☐ Insomnia
☐ Snoring
☐ Daytime drowsiness

Skin & Hair
- ☐ Rashes
- ☐ Acne
- ☐ Eczema/Psoriasis
- ☐ Hair thinning/loss

Head, Eyes, Ears, Nose, Throat
- ☐ Headaches
- ☐ Sinus issues
- ☐ Vision changes
- ☐ Ringing in ears

Respiratory
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Chronic cough

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ High blood pressure

Digestive
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Food intolerances

Urinary/Reproductive
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Menstrual irregularities
- ☐ Libido changes
- ☐ Sexual dysfunction

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Back/neck pain

Neurological
- ☐ Dizziness
- ☐ Memory issues
- ☐ Numbness/tingling

Mood & Mental Health

☐ Anxiety
☐ Depression
☐ Mood swings
☐ Brain fog

Preventive Wellness Screenings

Please indicate the **date of your most recent screening** or write **"Never"**

Screening Test	**Date of Last Test**	**Results/Notes**
Colonoscopy		
Mammogram		
Pap smear/pelvic exam		
Prostate exam (PSA)		
DEXA (bone density)		
Eye exam		
Dental exam		
Hearing test		
Flu vaccine		
COVID vaccine/boosters		
Pneumococcal vaccine		
Tetanus/Tdap vaccine		
Shingles vaccine (Shingrix)		

Functional Timeline (Optional)

Please list major life events, illnesses, traumas, or turning points in your health (e.g., childbirth, major stress, surgeries) by decade or age range.

Anything Else You'd Like Us to Know?