Wellspring Functional Health and Nutrition
301 East Carmel Drive, Suite 100-C
Carmel, IN 46032

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GENERAL INFORMATION

Name_____Preferred Name_____Date_____

Address_____City _____ State_____Zip Code_____

Home Phone_____Cell Phone_____Email_____

Emergency Contact Name: _____Emergency Contact Number: _____

Age:____Date of Birth:_____Height: _____Weight: _____Gender: Female_____Male_____

Circle one: Married Separated Divorced Widowed Single Partnership Do you have any children? Yes No

Occupation_____

Do you have insurance (Y or N)? Insurance Company name: _____

How did you hear about our clinic? Website_____Media_____Friend/ family member_____

Has any other family member already been a patient at the clinic?_____

Who is your primary medical physician?_____

Date of last menstrual period: _____Do you have irregular periods? Yes No

If yes, please describe: _____

Are you on birth control or hormone replacement therapy? Yes No
If yes, brand/dosage & how long: _____

Do you exercise? Yes No How often? _____ What type? _____

Do you take Probiotics and/or Vitamin D? _____Brand/Dosage: _____

Do you have blood sugar swings, feel tired after eating, sugar cravings? (circle all that apply)

Have you ever had mononucleosis (Y or N) or an Epstein Barr diagnosis (Y or N) If yes, date of onset: _____

Have you ever had a tick bite? (Y or N). If yes, date: _____

Have you ever been diagnosed with Lyme Disease? (Y or N) If yes, date: _____

Do you have a history of NSAID (ibuprofen, tramadol, mobic, etc…) use? _____

Have you had any recent/prior diagnoses (if so, please list)?_____

Do you have high blood pressure?_____

Have you ever lived or travelled outside the United States? Yes_____No_____If yes, when and where?_____

_____

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

_____

Have you experienced any major losses in life? Yes___ No____ If yes, please comment:_____

_____

Do you have any allergies? Yes_____ No_____ If yes, what are you allergic to and what is your reaction?_____

Medications/Supplements

Please list all medications and supplements that you are currently taking.

BRAND	DOSAGE	DATE STARTED

Functional Assessment Questionnaire

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present. (Use the back of the page if necessary.)

PROBLEM	ONSET	FREQUENCY	SEVERITY

SOCIAL HISTORY

SLEEP/REST

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

Circle all that apply to you:

Trouble staying asleep Trouble falling asleep Mind racing/racing thoughts Feel rested upon awakening

TOBACCO HISTORY

Are you currently using tobacco? Yes____No_____How Long?_____ Previous tobacco user? Yes_____No_____How long?_____

What type? ☐ Cigarettes (Pack/Day?___) ☐ Cigar ☐ Pipe ☐ Smokeless ☐ Patch/Gum

ALCOHOL/DRUG USE

How many drinks currently per week (1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirit)

None_____1-3_____4-6_____7-10_____>10_____

Previous alcohol intake? Yes_____ (Mild___Moderate_____High___)

Previous or current drug use? Yes_____ No____ What types of drugs? _____

BOWEL HEALTH

Circle all that apply to you:

Constipation	Diarrhea	Bloating
Burping	Heartburn	Reflux

ESTABLISHING HEALTH GOALS

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality; a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

Have you made the decision to change? To do what it takes to get well? Yes_____ No_____

There is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

List up to 5 things that you have *been unable* to do as a result of your present symptoms. Please be specific.

_____

_____

_____

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

_____

_____

_____

Are there any other health goals you want to achieve?

_____

_____

_____

READINESS ASSESSMENT

Rate on a scale of 1 TO 5 (5 being very willing and 1 being not willing), in order to improve your health, how willing are you to :

Significantly modify your diet: 5_____ 4_____ 3_____ 2_____ 1_____

Take several nutritional supplements each day: 5_____ 4_____ 3_____ 2_____ 1_____

Modify your lifestyle: 5_____ 4_____ 3_____ 2_____ 1_____

Practice relaxation techniques: 5_____ 4_____ 3_____ 2_____ 1_____

Engage in regular exercise: 5_____ 4_____ 3_____ 2_____ 1_____

Have periodic lab tests to assess progress: 5_____ 4_____ 3_____ 2_____ 1_____

Comments: _____

_____

_____

_____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these medical forms will provide invaluable data. Each section builds upon the other, allowing me and other physicians the opportunity to discover the **"missing key"** that will solve your health problem. Once all the sections of this form and the questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation.

I thank you once again and look forward to helping you achieve a **"return to health and well being."**

Sincerely,

Tricia Fox, ND-S, CFMP

Health Check - Women's Symptom Review

Please review the symptom checklist below and indicate any symptoms you are experiencing

SYMPTOM	NONE	MILD	MODERATE	SEVERE	
Hot Flashes					**Estrogen Deficient**
Night Sweats					
Vaginal Dryness					
Incontinence					
Irregular Periods					**Progesterone Insufficiency**
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					**HPA Axis (Adrenal) Dysfunction**
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Nervous					
Ringing in Ears					
Fibromyalgia					
Allergies					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					**Thyroid**
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Concerns					**Metabolic Syndrome - High Androgens**
Acne					
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain-Hips					
Weight Gain-Waist					
Hot Flashes Hot Flashes Hot Flashes					
High Cholesterol					
Elevated Triglycerides					
Decreased Libido					**Low Androgens**
Decreased Muscle Size					
Thinning Skin					
Rapid Aging					
Aches & Pains					
Bone Loss					

Health Check - Men's Symptom Review

Please review the symptom checklist below and indicate any symptoms you are experiencing

SYMPTOM	NONE	MILD	MODERATE	SEVERE	
Decreased Urine Flow					**Progesterone Insufficiency**
Increased Urinary Urge					
Prostate Problems					
Weight Gain – Chest / Hips					**Metabolic Syndrome - Low Androgens**
Weight Gain – Waist					
Decreased Libido					
Decreased Erections					
Ringing in Ears					
High Cholesterol					
Elevated Triglycerides					
Hot Flashes					
Night Sweats					
Decreased Mental Sharpness					
Increased Forgetfulness					
Decreased Muscle Size					
Decreased Flexibility					
Sore Muscles					
Increased Joint Pain					
Neck or Back Pain					
Bone Loss					
Rapid Aging					
Thinning Skin					
Decreased Stamina					
Burned Out Feeling					
Infertility Concerns					
Stress					**HPA Axis (Adrenal) Dysfunction**
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Apathy					
Depressed					
Foggy Thinking					
Anxious					
Irritable					
Nervous					
Headaches					
Sugar Cravings					
Dizzy Spells					
Allergies					
Cold Body Temperature					**Thyroid**
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					

NUTRITIONAL INFORMED CONSENT

1. **SERVICES**: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and am informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients pertain to the functional health/whole body concept and that Wellspring Functional Health and Nutrition is not a diagnosing practice. I understand that in order to obtain services from Wellspring Functional Health and Nutrition I must be established with a traditional allopathic physician for all routine and preventative screenings such as bone density, mammograms, pap smears, prostate testing, colonoscopy, etc. and that I will not hold Wellspring Functional Health and Nutrition or Tricia Fox liable for undiagnosed conditions as a result of my inaction to seek primary allopathic care and routine screenings for disease.

2. **NO GUARANTEE**: I have been informed that the methods of nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased.

3. **RISKS**: I understand the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that may be recommended are generally considered safe, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I also understand that nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients.

4. **PREGNANCY**: I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

5. **ALTERNATIVES**: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. **QUESTIONS AND ANSWERS**: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature_____ Date_____

Name (printed)_____

Financial Agreement

Cash Payment

We would like to take a moment to welcome you to our office and assure you that you will be receiving the very best care available. In order to familiarize you with the financial policies of our office, I would first like to explain how your bills will be handled.

It is our policy in this office to maintain your account on a current basis. Charges for treatment are DUE AND PAYABLE at the time the service is provided. We accept cash, check, or credit card (Visa & MasterCard). We ask that you make payments on a PER VISIT BASIS. If you accrue a balance, it is also understood that you are responsible for any collection costs incurred. If you need to make alternate payment arrangements, then please let us know. Often times we can reach an appropriate solution.

Once again, we would like to welcome you to our office. If you have any questions at any time, please feel free to ask.

I have read and agree to the above.

Signature_____ Date_____

Name (printed)_____

*Please be kind enough to give us a 24 hour notice if you must change or cancel you appointment. Our office policy requires a $30.00 cancellation fee if adequate notice is not given. (Legitimate emergencies accepted.)