WOMENS HEALTH HISTORY

ABOUT YOU

NAME:		
ADDRESS:		
CITY:	STATE/ZIP CODE:	
HOME PHONE:	CELL PHONE:	
EMAIL ADDRESS:		
DATE OF BIRTH:	AGE:	GENDER:
WHOM MAY WE THANK FOR REFERRING YOU?		

DATE OF MOST RECENT BLOOD WORK:
DESCRIBE ANYTHING SIGNIFICANT FROM YOUR CHILDHOOD:
DID YOU / DO YOU RECEIVE VACCINATIONS?

OFFICE USE ONLY

REASON FOR YOUR VISIT

List your 3 main goals / health concerns in order of importance.

1.

2.

3.

WHEN DID THESE CONCERNS BEGIN?

DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE IN ANY WAY?

WHAT (if anything) HAVE YOU DONE TO ADDRESS YOUR CONCERNS?

RESULTS:

GOALS FOR YOUR CARE

center for FUNCTIONAL MEDICINE

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HORMONE HISTORY

ARE YOU PREGNANT? ❑ NO ❑ YES	**ARE YOU NURSING?** ❑ NO ❑ YES
ARE YOUR PERIODS REGULAR?	**HOW MANY DAYS IS YOUR FLOW?**

BIRTH CONTROL HISTORY

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

❑ Premenstrual tension	❑ Thyroid issues / on thyroid medication
❑ Painful menses (cramping, etc)	❑ Difficulty losing weight
❑ Excessive flow or prolonged menstruation	❑ Reduced initiative and/or mental sluggishness
❑ Painful / tender breasts	❑ Easily fatigued, sleepy during the day
❑ Menstruate too frequently	❑ Sensitive to cold, poor circulation (cold hands and feet)
❑ Acne, worse at menses	❑ Dry or scaly skin
❑ Depressed feelings before menstruation	❑ "Ringing" in ears/noises in head
❑ Vaginal discharge	❑ Hearing impaired
❑ Menses scanty or missed	❑ Constipation
❑ Hysterectomy / ovaries removed	❑ Excessive falling hair and/or coarse hair
❑ Menopausal hot flashes	❑ Headaches when waking that wear off during the day
❑ Sex drive reduced or absent	❑ Increased ability to eat sugar without symptoms
❑ Abnormal thirst	❑ Menstrual disorders (women)
❑ Weight gain around hips or waist	❑ Lack of menstruation (young girls)
❑ Tendency to ulcers or colitis	❑ Lactation problems & issues producing breast milk

DO YOU HAVE A HISTORY OF: ❑ Hypoglycemia ❑ Adrenal Dysfunction ❑ Depression ❑ Diabetes ❑ Osteoporosis ❑ Menopause ❑ Alzheimer's ❑ Thyroid Dysfunction ❑ Hormone Related Cancer ❑ Fibrocystic Breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ Uterine Fibroids

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE ABOVE?

PREVIOUS PREGNANCY HISTORY

# OF PREGNANCIES? **# OF BIRTHS?**	**LENGTH OF ACTIVE LABOR(S):**

CHILDREN (BIRTH DATES & NAMES)

PLEASE CHECK ANY OF THE FOLLOWING THAT HAVE BEEN USED:

- ❑ EPIDURAL
- ❑ PITOCIN
- ❑ FORCEPS
- ❑ VACUUM
- ❑ VAGINAL BIRTH
- ❑ C-SECTION
- ❑ BREECH PRESENTATION
- ❑ OTHER:

DID YOU EXPERIENCE ANY OF THE FOLLOWING:

- ❑ GESTATIONAL DIABETES
- ❑ PRE-ECLAMPSIA
- ❑ ANEMIA
- ❑ OTHER:

DESCRIBE ANY HEALTH ISSUES, COMPLICATIONS OR CONCERNS YOU HAVE HAD WITH PREVIOUS PREGNANCIES:

PLEASE CHECK IF ANY OF THE FOLLOWING PRACTITIONERS PARTICIPATED IN YOUR PRE-NATAL CARE. You may share their information if you so choose!

- ❑ OB/GYN _____
- ❑ MIDWIFE _____
- ❑ DOULA _____
- ❑ CHIROPRACTOR _____
- ❑ CRANIOSACRAL _____
- ❑ MASSAGE _____
- ❑ NUTRITION/HEALTH COACH_____

STRESS & ADRENAL PROFILE

ARE YOU ON BLOOD PRESSURE MEDS? ❑ NO ❑ YES	**HISTORY OF BLOOD SUGAR ISSUES ?** ❑ NO ❑ YES
WHAT IS YOUR "NORMAL" BLOOD PRESSURE?	**DO YOU WORK 3rd SHIFT?**

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- ❑ Blood pressure low or dizziness when you stand or bend forward
- ❑ Crave salt
- ❑ Chronic fatigue / get drowsy / afternoon yawning
- ❑ Inability to handle stress
- ❑ Weakness / dizziness / fainting spells
- ❑ Weakness after colds / slow recovery
- ❑ Chronic inflammation, infection, illness or pain
- ❑ Immune imbalances or autoimmunity
- ❑ Subject to colds, asthma, bronchitis, respiratory issues
- ❑ Allergies and / or hives, rashes or other skin problems
- ❑ Slow starter in the morning
- ❑ Dependent on caffeine or stimulants
- ❑ Weight loss resistance (despite proper diet & exercise)
- ❑ Symptoms of / or history of thyroid issues
- ❑ Hormone imbalances (PMS, amenorrhea, menopausal symptoms)
- ❑ Prone to depression (including post-partum depression)
- ❑ History of anxiety or increased fears
- ❑ Difficulty maintaining or holding adjustments
- ❑ Attention or focus issues, learning difficulties
- ❑ Nails weak or ridged
- ❑ Excessive sweating with little or no activity
- ❑ Poor circulation
- ❑ Afternoon headaches
- ❑ Difficulty falling asleep or other sleep disturbances
- ❑ History of blood sugar issues
- ❑ Crave sweets or coffee in afternoon or mid-morning
- ❑ Adult onset diabetes, excessive urinations, or sugar in urine
- ❑ Hungry between meals or excessive appetite
- ❑ Irritable before meals
- ❑ Get "shaky" or light-headed if meals delayed
- ❑ Heart palpitates if meals missed or delayed
- ❑ Dizziness, irritability or fatigue relieved by food
- ❑ Sleepy or tired immediately after eating a meal
- ❑ Awaken few hours after sleep, hard to get back to sleep

DOES THIS SOUND LIKE YOU? ❑ NO ❑ YES

I crash after lunch in the afternoon.
I get a burst of energy around 6 p.m.
I get sleepy around 9—10pm (which I often resist)
I get my "second wind" around 11pm,
then can't fall asleep until 1am

OFFICE USE ONLY:

Ragland's

Cortisol / DHEA

CAR

Neurotransmitters

Nutrients

Rate the following questions on a frequency scale of 1-5. 1= Never 2= Rarely 3= Occasional 4= Regularly 5= Constantly												
If pain is present, how stressed are you about it?	1	2	3	4	5	Being overly worried about small things	1	2	3	4	5
Presence of negative or critical feelings about self	1	2	3	4	5	Difficulty thinking or concentrating	1	2	3	4	5
Experience moodiness, temper, or angry outbursts	1	2	3	4	5	Experience vague fears or anxiety	1	2	3	4	5
Difficulty falling or staying asleep.	1	2	3	4	5	Being fidgety or restless; difficulty sitting still	1	2	3	4	5
Experience depression or lack of interest.	1	2	3	4	5	Tend to be perfectionist or procrastinate	1	2	3	4	5
Experience a fast paced daily life	1	2	3	4	5	Tend to hold in feelings, lack expression	1	2	3	4	5
Experience verbal or physical abuse	1	2	3	4	5	Sickness of loss of loved one	1	2	3	4	5

Rate the following based on how much stress they cause you. 1= None 2= Slight 3= Moderate 4= Pronounced 5= Extensive											
Family	1	2	3	4	5	School	1	2	3	4	5
Significant relationship	1	2	3	4	5	Career	1	2	3	4	5
Health	1	2	3	4	5	Emotional well-being	1	2	3	4	5
Finances	1	2	3	4	5	Coping with daily problems	1	2	3	4	5

Rate the following questions on a scale of 1-5. 1= Terrible 2= Unhappy 3= Mostly Dissatisfied 4= Mixed 5= Mostly Satisfied 6=Pleased 7=Delighted														
Your personal life	1	2	3	4	5	6	7	Your extended family	1	2	3	4	5	6	7
Your immediate family	1	2	3	4	5	6	7	Your job / career	1	2	3	4	5	6	7

OTHER LIFESTYLE HABITS

Circle the habits and frequencies that apply to you. If multiple apply, can use the space on the line to describe / differentiate.

YOGA | TAI CHI | QI GONG	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER
FOCUSED BREATHING | MEDITATION | PRAYER	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER
CHIROPRACTIC CARE	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER
ACUNPUNCTURE | REIKI | HEALING TOUCH	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER
MASSAGE | CRANIALSACRAL | OTHER BODY WORK	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER
READ | WATCH | LISTEN TO SOMETHING INSPIRATIONAL AND POSITIVE	DAILY	WEEKLY	MONTHLY	YEARLY	NEVER

NUTRITIONAL OVERVIEW

INSTRUCTIONS: *Please check all that apply to your normal lifestyle routine. In the blank space, describe how often and/or how much is consumed.*

❑ HOME-COOKED MEALS	❑ FAST FOOD	❑ FRUITS	❑ VEGGIES	❑ FRUIT JUICES	❑ FRESH PRESSED JUICE
❑ CARBONATED BEVERAGES	❑ TEAS / HERBS	❑ COFFEE	❑ FILTERED WATER	❑ ALCOHOL	❑ PROTEIN POWDER
❑ NON-ORGANIC MEAT	❑ ORGANIC MEAT	❑ FISH	❑ RICE	❑ GLUTEN-FREE	❑ DAIRY-FREE
❑ ARTIFICIAL SWEETENERS	❑ NATURAL SWEETENERS	❑ CANDY	❑ GUM	❑ TOBACCO USE	❑ CANNABINOIDS / CBD

TYPE OF MILK	**MOST COMMONLY USED SWEETENERS**	**TYPE OF BUTTER**
HOW MANY MEALS DO YOU EAT A DAY (ON AVERAGE)?	**MOST COMMONLY CONSUMED TYPE OF WATER** (I.E. tap, bottled, RO, alkaline):	

DO YOU DRINK LIQUIDS WITH MEALS? ❑ NO ❑ YES — HOW MUCH WATER DO YOU DRINK DAILY?

DO YOU FEEL CHRONICALLY DEHYDRATED WITH ADEQUATE WATER INTAKE? ❑ NO ❑ YES

DO YOU EAT BREAKFAST? ❑ NO ❑ YES
If so, what?

BOWEL HABITS & DIGESTIVE FUNCTION

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT?

DO YOU HAVE TO STRAIN TO RELEASE YOUR BOWELS? ❑ NO ❑ YES

DO YOU USE LAXATIVES OR STOOL SOFTENERS? ❑ NO ❑ YES

DO YOU HAVE A BOWEL MVMT WITHIN 1 HOUR OF WAKING? ❑ NO ❑ YES

DO ANY OF THE FOLLOWING REPEATEDLY APPEAR? ❑ CONSTIPATION ❑ DIARRHEA ❑ GAS ❑ BLOATING ❑ HEART BURN ❑ INDIGESTION ❑ REFLUX ❑ HEMORRHOIDS

WOULD YOU SAY YOUR STOOLS ARE THE CONSISTENCY OF TOOTHPASTE? ❑ YES ❑ NO, HARDER ❑ NO, LOOSER

DO YOU TAKE A PROBIOTIC? ❑ YES ❑ NO
If so, what kind?

HAVE YOU TAKEN ANTIBIOTICS? ❑ YES ❑ NO
If so, when?

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

❑ History of antacid use	❑ Pass large amounts of foul smelling gas
❑ Bad breath, halitosis	❑ Irritable bowel or mucus colitis
❑ Loss of taste for high protein foods (meat)	❑ Dairy and/or gluten products cause distress
❑ Burning or nervous stomach relieved by eating	❑ Eyes and nose watery and/or puffy
❑ Gas shortly after eating	❑ Pulse speeds after meals and/or heart pounds when resting
❑ Indigestion 30-60 min after eating, may last 3-4 hours	❑ Food sensitivities or intolerances
❑ Difficulty digesting fruits and/or veggies	❑ Dark circles under eyes
❑ Undigested foods found in stools	❑ History of gall bladder stones / attacks
❑ Acid or spicy food upsets stomach	❑ Gall Bladder has been removed

LIVER & GALL BLADDER FUNCTION

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

❑ Yellowish cast to eyes	❑ Lower bowel gas/bloating several hours after eating
❑ Cold at "the core"	❑ Headaches over eyes
❑ Chronic fatigue or malaise	❑ Feel nauseous, queasy or gag easily
❑ Hard, dry or pale stools	❑ Color of stools light brown or yellow
❑ Dark areas or bags under eyes	❑ Greasy or high fat foods cause distress
❑ Dry, flaky, itchy skin and/or skin peels on soles of feet	❑ Undigested fats in bowels; oily or sticky stools
❑ Feet itch or burn	❑ Pain between shoulder blades
❑ Sensitivity to hot weather	❑ Dark circles under eyes
❑ Vivid, bizarre dreams / nightmares	❑ "Acid" breath
❑ Burning or itching anus	❑ Appetite reduced
❑ Tenderness under right rib cage	❑ Postnasal drip
❑ Brown spots or bronzing of skin	❑ History of gallbladder attacks/stones
❑ Bitter metallic taste in mouth (especially in the AM)	❑ Depression / headaches or mental confusion
❑ Blurred vision	❑ Weight loss resistance and/or increased belly fat
❑ Bruise easily or slow wound healing	❑ Blood sugar issues / crave sweets

DO YOU HAVE A HISTORY OF: ❑ Leaky Gut or Intestinal Permeability ❑ SIBO ❑ Alcoholism ❑ Substance Abuse ❑ Chemotherapy ❑ Gall Bladder Removed ❑ Fatty Liver ❑ Cirrhosis ❑ Hepatitis

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE ABOVE?

LIVER DETOXIFICATION ASSESSMENT

SLUGGISH PHASE 1

Does caffeine over-stimulate you? ❑ NO ❑ YES	**Do you have intolerance to alcohol?** ❑ NO ❑ YES

Have you been previously diagnosed with SIBO (Small Intestinal Bacteria Overgrowth)? ❑ NO ❑ YES

Do you have sensitivities to environmental toxins, perfumes , fragrances and/or other chemicals? ❑ NO ❑ YES

Check any of the following that you have taken: ❑ Benzodiazepines ❑ Antihistamines ❑ Ketoconazole ❑ Sulfaphenazole ❑ Antacids or PPI's ❑ Cimetidine ❑ Curcumin ❑ Grapefruit Juice

OVERACTIVE PHASE 1

Are you unaffected by caffeine? ❑ NO ❑ YES	**Do you consume alcohol regularly?** ❑ NO ❑ YES
Do you smoke cigarettes? ❑ NO ❑ YES	**Do you react adversely to medications/drugs?** ❑ NO ❑ YES

Do you have a high protein diet or consume red meat frequently ? ❑ NO ❑ YES

Circle any drugs/chemicals that you are or have been exposed to: ❑ Acetate ❑ Alcohol ❑ Barbiturates ❑ Carbon Tetrachloride ❑ Dioxin ❑ Exhaust or paint fume ❑ Nicotine in cigarette smoke ❑ Pesticides (Organophosphorus) ❑ Phenobarbital ❑ Steroid hormones ❑ Sulphonamides (sulpha drugs) ❑ Birth Control

SLUGGISH PHASE 2

Are you susceptible to hangovers? ❑ NO ❑ YES	**Do you have issues/reactions to garlic or onion?** ❑ NO ❑ YES
Have you had toxemia in pregnancy? ❑ NO ❑ YES	**Does your urine have a strong smell after eating asparagus?** ❑ NO ❑ YES
Is your diet LOW in ... ❑ FAT ❑ PROTEIN	**Have you consumed alcohol for a long period of time ?** ❑ NO ❑ YES

Do you take aspirin and/or other NSAIDS (including ibuprofen, aspirin, Advil, Nuprin, etc) ? ❑ NO ❑ YES

Do you have estrogen dominance, hormone or neurotransmitter imbalances, allergies, or elevated cortisol with insomnia? ❑ NO ❑ YES

Circle any drugs/chemicals that you are or have been exposed to: ❑ Acetate ❑ Alcohol ❑ Barbiturates ❑ Carbon Tetrachloride ❑ Dioxin ❑ Exhaust or paint fume ❑ Nicotine in cigarette smoke ❑ Pesticides (Organophosphorus) ❑ Morphine ❑ Phenobarbital ❑ Steroid hormones ❑ Sulphonamides (sulpha drugs) ❑ Birth Control

PERSONAL HYGIENE

SKIN & BODY CARE PRODUCTS

DO YOU USE SUNSCREEN? ❑ NO ❑ YES
What kind?

DO YOU USE DEODERANT? ❑ NO ❑ YES
What kind?

HOW DO YOU SHOP FOR YOUR PERSONAL HYGIENE AND BODY CARE PRODUCTS?
(I.E. price, clean ingredients, dermatologist recommendation, other)

ARE YOU OPEN TO RECOMMENDATIONS / ALTERNATIVES? ❑ NO ❑ YES

What products do you try to source "clean", organic or verified by the EWG?: ❑ Toothpaste ❑ Skin Care ❑ Body Care ❑ Hair Care ❑ Make-up ❑ Detergents ❑ Cleaners

HOME HYGIENE

DO YOU OPEN WINDOWS IN YOUR HOME OFTEN? ❑ NO ❑ YES

DO YOU HAVE WI-FI IN YOUR HOME? ❑ NO ❑ YES
Do you turn it off at night or when not using?

WHAT KIND OF LAUNDRY SOAP DO YOU USE?

WHAT KIND OF HAND SOAP DO YOU USE?

WHAT KIND OF DISH SOAP DO YOU USE?

WHAT KIND OF CLEANING SPRAYS OR SUPPLIES DO YOU USE?

HAVE YOU EVER HAD WATER DAMAGE IN YOUR HOME? ❑ NO ❑ YES

HAVE YOU EVER HAD SEWAGE OR PLUMBING ISSUES IN YOUR HOME? ❑ NO ❑ YES

HAVE YOU HAD YOUR HOME INSPECTED / TESTED FOR AIR QUALITY, MOLD, OR OTHER CONTAMINANTS? ❑ NO ❑ YES
If yes, results?

CARDIOMETABOLIC ASSESSMENT

NAME OF CARDIOLOGIST?
(if applicable)

DO YOU HAVE A FAMILY HISTORY OF ANY CARDIOVASCULAR DISEASE? ❑ NO ❑ YES

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

- ❑ History of high blood pressure
- ❑ History of high triglycerides
- ❑ History of elevated blood sugar or diabetes
- ❑ Dull pain in chest and/or pain radiating into left arm
- ❑ Aware of heavy and/or irregular breathing
- ❑ Discomfort in high altitudes
- ❑ "Air hunger" / sigh frequently
- ❑ Swollen ankles (worse at night)
- ❑ Shortness of breath with exertion
- ❑ Physically inactive
- ❑ Taking high blood pressure medication
- ❑ Taking high cholesterol medication
- ❑ Taking blood thinning medication
- ❑ History of heart attack or cardiac event
- ❑ History of stroke
- ❑ History of varicose veins
- ❑ History of gestational diabetes
- ❑ History of polycystic ovary syndrome (PCOS)

HAVE YOU HAD ANY OF THE FOLLOWING TESTS DONE:

- ❑ Boston Heart
- ❑ Stress Test
- ❑ Calcification Screening
- ❑ Micronutrient Evaluation
- ❑ Fatty Acid Assessment

OFFICE USE ONLY:

Total Chol	*Homocysteine*
TAG	*Fibrinogen*
HDL	*HS-CRP*
LDL	*Genetics*
VLDL	*Vitamin A | D | E | K*

general HEALTH HISTORY

NAME: _____ **DATE:** _____

DIRECTIONS:

Please read each description and circle the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom, put a ? *before* the symptom's number.

KEY: 0 = Never 1 = Mild 2 = Moderate 3 = Severe

MINERALS				
1. Frequent skin rashes and/or hives	0	1	2	3
2. Muscle-leg-toe cramping at rest and/or while sleeping	0	1	2	3
3. Fever easily raised / fevers common	0	1	2	3
4. Crave chocolate	0	1	2	3
5. Feet have bad odor	0	1	2	3
6. Hoarseness frequent	0	1	2	3
7. Difficulty swallowing	0	1	2	3
8. Joint stiffness after rising	0	1	2	3
9. Vomit frequently	0	1	2	3
10. Tendency to anemia	0	1	2	3
11. "whites" of eyes (sclera) blue	0	1	2	3
12. "Lump" in throat	0	1	2	3
13. Dry mouth, eyes, and/or nose	0	1	2	3
14. White spots on finger nails	0	1	2	3
15. Cuts heal slowly and/or scar easily	0	1	2	3
16. Reduced or "lost" sense of taste and/or smell	0	1	2	3
17. Susceptible to colds, fevers, and/or infections	0	1	2	3
18. Strong light irritates eyes	0	1	2	3
19. Noises in head or ringing in ears	0	1	2	3
20. Burning sensations in mouth	0	1	2	3
21. Numbness in hands and feet (extremities "go to sleep")	0	1	2	3
22. Intolerant to MSG (monosodium glutamate)	NO		YES	
23. Cannot recall dreams	0	1	2	3
24. Nose bleeds frequent	0	1	2	3
25. Bruise easily, "black and blue" spots	0	1	2	3
26. Muscle cramps, worse with exercise ("charley horses")	0	1	2	3

MICROBIOME				
1. Coated tongue or "fuzzy" debris on tongue	0	1	2	3
2. Nasal congestion or discharge	0	1	2	3
3. Restless, figidity	0	1	2	3
4. Unproductive cough at night or while at rest	0	1	2	3
5. Urinary urgency or frequency	0	1	2	3
6. Burning on urination	0	1	2	3
7. Burning or itching anus	0	1	2	3
8. Bedwetting	0	1	2	3
9. Grind teeth at night	0	1	2	3
10. Recurrent ear infections or fluid in ears	0	1	2	3
11. Ear pain or deafness	0	1	2	3
12. Fingernail or toe nail fungus	0	1	2	3
13. Skin peeling on bottom of feet or hands	0	1	2	3

MAGNESIUM				
1. Blood pressure increased / on BP medication	0	1	2	3
2. Headaches	0	1	2	3
3. Hot flashes	0	1	2	3
4. Difficulty falling asleep	0	1	2	3
5. Tingling extremities or Restless Legs Syndrome	0	1	2	3
6. WOMEN ONLY: Hair growth on face or body	0	1	2	3
7. WOMEN ONLY: Masculine tendencies	0	1	2	3

CARDIOMETABOLIC				
1. Aware of heavy and/or irregular breathing	0	1	2	3
2. Discomfort in high altitudes	0	1	2	3
3. "Air hunger" / sigh frequently	0	1	2	3
4. Swollen ankles (worse at night)	0	1	2	3
5. Shortness of breath with exertion	0	1	2	3
6. Dull pain in chest and/or pain radiating into left arm	0	1	2	3
7. High blood pressure (with or without medication)	0	1	2	3
8. History of heart attack or cardiac event	0	1	2	3

B VITAMINS and FOLATE NEED				
1. Muscle soreness after moderate exercise	0	1	2	3
2. Vulnerability to insect bites—Especially fleas & mosquito	0	1	2	3
3. Loss of muscle tone or "heaviness" in arms or legs	0	1	2	3
4. Enlarged heart and/or heart failure	0	1	2	3
5. Worrier, feel insecure and/or highly emotional	0	1	2	3
6. Lack of concentration1	0	1	2	3
7. Pulse slow/below 65 or irregular pulse	NO		YES	
8. "Splitting" type headaches	0	1	2	3
9. Memory failing	0	1	2	3
10. Tolerance for sugar reduced	0	1	2	3

SECTION H—HEAVY METALS				
1.. Difficulty gaining weight, even if large appetite	0	1	2	3
2. Heart palpitations	0	1	2	3
3. Nervous, emotional, and/or can't work under pressure	0	1	2	3
4. Insomnia	0	1	2	3
5. Inward trembling	0	1	2	3
6. Night sweats	0	1	2	3
7. Fast pulse at rest	0	1	2	3
8. Intolerant to high temperatures	0	1	2	3
9. Easily flushed	0	1	2	3

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

center for FUNCTIONAL MEDICINE

4375 Georgetown Road | Indianapolis | IN | 46254
tel | 317.617.3542 fax | 317.245.8100
support@drbenakovich.com
www.DrBenakovich.com

Patient Name: _____

Birthdate: _____ Phone: _____

Address: _____

Parent/Guardian Name : _____

I hereby authorize _____
(name of practitioner or facility) *(fax number)*

to take the following action:

ACTION REQUESTED:

- ☐ Provide a copy of **my health information** to me
- ☐ Release **my health information** to:
- ☐ Discuss **my health information** with:
- ☐ Obtain copies of **my health information** from:

CENTER FOR FUNCTIONAL MEDICINE	records@drbenakovich.com	317.647.1007
(name of other person, provider, or entity)	(email)	(fax number)

4375 GEORGETOWN RD	INDIANAPOLIS	IN	46254
street address	city	state	zipcode

For the dates of service from: _____to _____.

(records will be provided for all service dates if left blank)

PATIENT SIGNATURE: (Parent of guardian if applicable)	DATE:

COMMUNICATION AUTHORIZATION

FOR PRIVATE USE OF EMAIL, PHONE AND TEXT

In order to communicate more efficiently with our patients, the Provider (Lauren Benakovich DC and/or Center for Functional Medicine) may use email, text and/or voicemail regarding our patients for non-urgent messages. These communications may include, but not limited to: appointment confirmations, scheduling, general questions, invoicing and billing information, communications with mutual health care providers, release of medical information and test results.

The Provider offers patients the opportunity to communicate by e-mail, text messages or voicemail. Transmitting patient information by e-mail, text messages or voicemail, however, has a number of risks that patients should consider before using e-mail, text messages or voicemail ("E-Messages"). These include, but are not limited to, the following risks:

- E-Messages can be circulated, forwarded, and stored in paper and electronic files
- E-Messages senders can easily misaddress an e-mail, text messages or voicemail
- E-Messages are easier to falsify than handwritten or signed documents
- Backup copies of E-Messages may exist even after the sender of the recipient has deleted his or her copy
- Employer and on-line services have a right to archive and inspect E-Messages transmitted through their systems
- E-Messages can be intercepted, altered, forwarded, or used without authorization or detection and can be received by many intended and unintended recipients
- E-Messages can be used to introduce viruses into computer systems

The Provider will use reasonable means to protect the security and confidentiality of e-mail, text messages or voicemail ("E-Messages") information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail, text messages or voicemail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of E-Messages for patient information which includes the following conditions:

- All E-Messages to or from the patient concerning diagnosis or treatment may be forwarded internally to Provider's staff as necessary and/or printed and added to the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails or text messages.
- Although Provider will endeavor to read and respond promptly to an E-Message from the patient, Provider cannot guarantee that any particular E-Messages will be read and responded to within any particular period of time. Thus, the patient shall not use E-Messages for medical emergencies or other time-sensitive matters.
- If the patient's E-Messages requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the E-Messages and when the recipient will respond.
- The patient should not use e-mail, text messages or voicemail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, metal health, developmental disability, or substance abuse.
- The patient is responsible for protecting his/her password of other means to access to e-mail, text messages or voicemail. Provider is not liable for breaches of confidentiality caused by the patient or third party.
- Provider shall not engage in e-mail, text messages or voicemail communication that is unlawful, such as unlawfully practicing medicine across state lines.
- It is the patient's responsibility to follow up and/or schedule and appointment if warranted.

Please initial the following choices to indicate your agreement and acceptance:

_____ **E-MAIL :**

I authorize Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC to use electronic mail (e-mail) to contact me and/or other professionals involved in my or my child's care. I am aware that Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC does not use any specialized encrypted email software and cannot guarantee that information transmitted via e-mail will not be intercepted by other parties. By signing this form, I agree to not hold Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC or its employees responsible for any breach of confidentiality that may occur by someone else accessing the information continued in any emails sent to or from Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC regarding my or my child's personal health information. I understand that reasonable means will be used to protect the security and confidentiality of the email. All concerns to and from me regarding my or my child's personal health information will be a part of my or my child's medical record and can be viewed by healthcare and insurance providers and Dr Lauren's office support staff. My email will not be forwarded outside the office without my consent or as required by law.

Authorized email address: _____

Authorized email address: _____

_____ **VOICEMAIL :**

Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC has my permission to leave detailed clinical information on my voicemail or answering machine including but not limited to messages regarding appointments.

_____ **TEXT MESSAGES :**

Lauren Benakovich D.C. and/or Center for Functional Medicine, LLC has my permission to send clinical information to my cell phone including but not limited to messages regarding appointments.

Authorized mobile number(s): _____

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail, text messages or voicemail between Provider and me, and hereby give my authorization to communicate with me, the patient, by e-mail, text messages or voicemail. Any questions I may have had were answered.

Patient Name: _____ Date: _____

Signature of Patient, Parent or Legal Guardian: _____

Signature of Witness: _____ Date: _____