17875 Von Karman Ave
Suite 150, Irvine, CA 92614

OC Functional Nutritionis Intake with Saundi, Nutritionist

Welcome!

Because our medical philosophy addresses not only symptoms but also the root cause of disease, our approach requires more work. We believe it's worth the effort, and we will work together with you as a team.

Please complete all forms 48 hours before your first appointment so that we may have time to review your information before your visit.

Please let us know if you have any questions along the way. We are here for YOU. We look forward to working with you!

TELL US MORE ABOUT YOU

Primary Contact Details

Caregiver First Name _____

Caregiver Last Name _____

Email * _____

Home Phone _____

Mobile Phone _____

Work Phone _____

Fax _____

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 * _____

Address Line2 _____

City * _____

Country * _____

State * _____

Zip code * _____

Postbox No _____

Emergency Contact Name _____

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Emergency Contact Number

Extn

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Insurance Details

Insurance Type * ☐ MEDICARE ☐ MEDICAID ☐ TRICARE CHAMPUS ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER

Insurance Plan Name or Program Name *

ID *

Insurance Company Name (Payer Name) *

Payer Id *

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Payer Address

Payer City

Payer Country

Payer State

Payer ZipCode

Valid From

Valid Until

Policy Group/FECA #

Copay

Deductible

Employer/School Name

Comments

Insured Person Details

Patient Relationship *

☐ Self ☐ Spouse ☐ Child
☐ Other

First Name *

Last Name *

Date of Birth *

Sex *

☐ Male ☐ Female ☐ Unknown

Address Line 1

Address Line 2

City

Country

State

Zip Code

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Home Phone

Mobile Phone

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

CONTEXT OF CARE REVIEW

How did you hear about us? *

Are any of your other family members working with us?

If you have a primary care doctor, please provide his/her name and contact information:

What three expectations do you have from your FIRST visit with us?

1) *

2)

3)

HEALTH CONCERNS

What are the primary health goal(s) you hope to achieve by working with nutrition and lifestyle-based therapies?

_ *

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When did your health concerns begin?

Was there a triggering event or illness that preceded your current health conditions?

FAMILY HISTORY

Any relevant family history?

CHILDHOOD ILLNESSES

Were you born vaginally or c-section?

Was your mother healthy before and during pregnancy?

Were you breast fed?

Did you suffer from eczema, chronic ear infections, asthma, allergies or any other recurring illness such as strep throat as a child?

Please check the conditions below that you have had:

- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella (German measles)
- ☐ Pertussis (whooping cough)
- ☐ Chicken pox
- ☐ Strep throat

Is there anything else that stands out in your childhood as something that may affect your health?

HOSPITALIZATIONS, SURGERIES, ACCIDENTS

Please list all hospitalizations, surgeries, and major accidents/traumas/concussions.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

What is your medical history that you would like us to know?

How many courses of antibiotics have you had in your lifetime, approximately? _____

LIFESTYLE

Current living situation *

☐ Live alone ☐ Live with spouse ☐ Live with spouse and children
☐ Live with children ☐ Live with roommate

Tobacco: *

☐ Yes, current everyday smoker ☐ Yes, occasional smoker ☐ Former smoker ☐ Never smoker

Do you exercise? * ☐ Yes ☐ No

Describe your exercise routine?

Do you drink alcohol-containing beverages? *

☐ Yes ☐ No ☐ Rarely ☐ Recovering alcoholic

If yes, how many drinks per week? _____

Do you consider your habits around drinking to be a problem? ☐ Yes ☐ No

Do you think alcohol plays a part if your current health goals? ☐ Yes ☐ No

Number of caffeinated beverages (coffee, decaf coffee, green or black tea, energy drinks, soda) per day: *

List 3 things you do in your weekly routine that promote health.

List 3 things you do in your weekly routine that decrease health.

If you could wave a magic wand and change one thing about your life, what would it be?

TRAVEL

Have you traveled internationally? If so, please note when and where.

Have you ever become sick during or after visiting another country?

FOR THE FOLLOWING, PLEASE CHECK

NEUROLOGICAL

Please check any of the following that you are experiencing:

- ☐ Paralysis, numbness, tingling
- ☐ Vertigo / dizziness
- ☐ Loss of balance or coordination
- ☐ Muscle weakness
- ☐ Tremors

ENDOCRINE

Please check any of the following that you are experiencing:

- ☐ Fatigue
- ☐ Overweight
- ☐ Underweight
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Hypoglycemia (low blood sugar)
- ☐ Cannot function if you skip a meal
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Often feel colder than others
- ☐ Often feel hotter than others
- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

IMMUNE

Cancer?

- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ No, never

Type(s) of cancer you have had or now have:

Please check any of the following that you are experiencing:

- ☐ Slow wound healing
- ☐ Chronic or recurring infections
- ☐ Always getting colds/flus
- ☐ History of reacting to a vaccine
- ☐ Night sweats
- ☐ Chronic fatigue

EARS

Please check any of the following that you are experiencing:

- ☐ Recurrent ear aches
- ☐ Recurrent ear infections
- ☐ Impaired hearing
- ☐ Ringing in ears
- ☐ Vertigo / dizziness

EYES

Please check any of the following that you are experiencing or have significantly experienced in the past:

- ☐ Impaired vision
- ☐ Double vision
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Tearing
- ☐ Dryness
- ☐ History of Lasik surgery

HEAD

Please check any of the following that you are experiencing:

- ☐ Headaches
- ☐ Migraines
- ☐ History of head Injury

NOSE AND SINUS

Please check any of the following that you are experiencing:

- ☐ Frequent colds/flus
- ☐ Stuffiness or sinus problems
- ☐ Nose bleeds
- ☐ Loss of smell
- ☐ Hayfever / Chronic Rhinitis

NECK

Please check any of the following that you may be experiencing:

- ☐ Pain or stiffness in neck
- ☐ Lumps in neck or goiter

MOUTH AND THROAT

Please check any of the following that you may be experiencing:

- ☐ Frequent sore throat
- ☐ Teeth grinding, clenching, or TMJ
- ☐ Pain or difficulty swallowing

SKIN AND HAIR

Please check any of the following that you may be experiencing:

- ☐ Eczema
- ☐ Rashes or hives
- ☐ Changes in skin color
- ☐ Acne or boils
- ☐ Lumps or bumps on skin
- ☐ Dry skin
- ☐ Noticeable hair loss or hair thinning
- ☐ Nails break/chip easily
- ☐ Hair growth in unusual places (eg: on the jaw in women)

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RESPIRATORY

Please check any of the following that you are experiencing:

- ☐ Cough, asthma, or wheezing
- ☐ Coughing up blood
- ☐ Bronchitis or pneumonia
- ☐ History of recurrent bronchitis or pneumonia
- ☐ Shortness of breath
- ☐ Shortness of breath when lying down
- ☐ Emphysema, Chronic Bronchitis, or COPD
- ☐ Tuberculosis
- ☐ History of tuberculosis

GASTROINTESTINAL

Please check any of the following that are currently a problem for you:

- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcer
- ☐ History of ulcer(s)
- ☐ Gallbladder disease
- ☐ Liver disease
- ☐ Pancreatitis
- ☐ Heartburn, reflux, or indigestion
- ☐ Abdominal pain or cramps
- ☐ Belching
- ☐ Flatulence
- ☐ Black stools
- ☐ Blood in stools
- ☐ Mucus in stools (looks like snot)

URINARY

Please check any of the following that apply to you:

- ☐ Increased frequency of urination
- ☐ Urinary frequency at night
- ☐ Urgency for urine - have to run to the bathroom
- ☐ Inability to hold in urine - having "accidents"
- ☐ Pain with urination
- ☐ Frequent urinary tract infections (UTIs)
- ☐ History of kidney stones

MUSCULOSKELETAL

Please check any of the following that apply to you:

- ☐ Joint pain or stiffness
- ☐ Arthritis
- ☐ History of broken bones
- ☐ History of hip or spine fracture
- ☐ Weakness
- ☐ Muscle spasms or cramps

Please mention the areas on your body where you are experiencing pain right now or on a regular basis:

CARDIOVASCULAR

Please check any of the following that apply to you:

- ☐ Heart disease
- ☐ Chest pain or angina
- ☐ Murmur
- ☐ History of blood clot(s)
- ☐ History of heart attack
- ☐ History of stroke
- ☐ Ankle swelling
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Fainting

BLOOD

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Please check any of the following that apply to you:

- ☐ Anemia
- ☐ Easy bleeding or easy bruising
- ☐ Cold hands/feet
- ☐ Varicose veins
- ☐ Hemorrhoids

Please check any of the following that apply to you:

- ☐ Painful periods
- ☐ Heavy or excessive flow
- ☐ PMS
- ☐ Bleeding or spotting between periods
- ☐ Endometriosis
- ☐ Ovarian cysts (current or past)
- ☐ Uterine fibroids
- ☐ Foul smell from vagina
- ☐ Abnormal vaginal discharge
- ☐ Pain with vaginal penetration
- ☐ Low libido
- ☐ Difficulty reaching orgasm
- ☐ Difficulty conceiving
- ☐ Breast pain or tenderness
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Menopausal symptoms

Nutrition

What changes, if any, have you made to your nutrition in the past that made you feel better or worse?

Which of these best describes you:

- ☐ I know how to eat to feel my best and that is how I eat.
- ☐ I know how to eat to feel my best but I struggle to stick to eating that way.
- ☐ I don't know how to eat to feel my best.

Do you practice a specific type of diet (paleo, gluten-free, low-carb, etc.)

Do you struggle to find meals and recipes that work for you lifestyle and/ or goals?

List 2 typical breakfasts

List 2 typical lunches

List 2 typical dinners

List 2 typical snacks

Do you regularly eat out of boredom?

Do you regularly eat past full?

Do you regularly snack after dinner?

Do you regularly eat foods that you consider to be unhealthy? If so, give 3-4 examples.

When faced with lifestyle changes around exercise, stress management, sleep and nutrition:

Do you find it hard to start with new habits / behaviors?

Do you find it hard to keep it going and make new habits / behaviors lasting?

Do you find that barriers and challenges from life get in the way and upset your progress?

Do you find adopting new habits / behaviors overwhelming and often feel stuck?

Do you find that you struggle to find the time and energy it takes to adopt new habits / behaviors?

Other information

Is there anything else you think we should know? Is there anything else that you would like to share about yourself or your health?