17875 Von Karman Ave
Suite 150, Irvine, CA 92614

OC Functional Nutritionist Intake Form

Welcome!

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

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

Please let me know if you have any questions along the way. I am here for YOU. I look forward to working with you!

TELL ME MORE ABOUT YOU

Primary Contact Details

First Name _____

Last Name _____

Date of Birth _____

Email _____

Home Phone _____

Mobile Phone _____

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 _____

Personal Details

Gender	☐ Male	☐ Female	☐ Unknown
Ethnicity	☐ Hispanic or Latino	☐ Not Hispanic or Latino	
Employment Status	☐ Employed ☐ Unemployed	☐ Full-Time Student ☐ Retired	☐ Part-Time Student
Marital Status	☐ Single	☐ Married	☐ Others
Smoking Status	☐ Current every day smoker ☐ Smoker	☐ Current some day smoker ☐ current status unknown	☐ Former Smoker ☐ Never Smoker ☐ Unknown if ever smoked

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

CONTEXT OF CARE REVIEW

How did you hear about OC Functional Nutritionist ?

Are any of your other family members working with OC Functional Nutritionist?

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 OC Functional Nutritionist?

1)

2)

3)

HEALTH CONCERNS

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

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) _____

What is your medical history that you would like OC Functional Nutritionist 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

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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

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BLOOD

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

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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.

Other information

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