



FUNCTIONAL HEALTH INSTITUTE

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Initial Consultation Instructions

If you have any recent labs (within 12 months), please bring them to your appointment.

If you are married or in a relationship, please bring your spouse or significant other with you to your appointment.

(There will be much information covered concerning your unique condition as well as the fundamentals of the program.)

Please bring all your supplements.

We require a 24-hour notice to change or cancel your appointment.

Note: If these steps are not followed, they may compromise the full value of your consultation.

Initial Consultation

Name: _____ Date: _____

AgeGender.....

Address:.....

Phone Number

Email Address

Main Complaints:

1) _____ 2) _____

3) _____ 4) _____

How long have you suffered with this problem? _____

Any other complaints: _____

Would you like improvement with any of the following?

Digestion: Reflux, Gas, Constipation

Sleep: Falling asleep or staying asleep

Sense of Well Being

Energy

What have you tried doing to resolve this problem that did not work?

Have you become discouraged or stressed about handling this problem?

When your problem is at its worst, how does it make you feel?

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

What effect does this have on your body functions? _____

Are you here visiting us to:

- Resolve my immediate problem
- Lifestyle program for optimized living
- Both
- Other: _____

How have you taken care of your health in the past? (Please circle)

Medications Holistic Routine medical Vitamins
Exercise Chiropractic Diet and Nutrition Other: _____

How did the previous methods work for you? _____

What are you afraid this might be or will be affecting without change? (Please circle)

Job Kids Marriage Sleep
Freedom Future abilities Finances Time

Are there any health conditions you are afraid this might turn into? (Please circle)

Diminished future abilities Surgery
Stress Arthritis
Weight gain Cancer
Heart disease Diabetes
Depression Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of?

What would be different or better without this problem? (Please circle)

Diminished stress Sleep More energy Work
Self-esteem Outlook Confidence Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?

What potential barriers do you foresee that would prevent these things from happening?

Do you feel it is possible to eliminate or prevent these potential barriers?

What are your strengths that will enable you to accomplish your goals?

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor in helping you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary to achieve your goals?

Thank You!