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Barnett Functional Medicine Associates

Dr. Patrick Barnett D.C. and Dr. Alicia Burns D.C.

Confidential Patient History:

Name____ Date____/____/____
Address_______________________ _______________________________________
City________________ State ___Zip _______E-Mail____________________________
Date of Birth__________________________Cell ________________________________
Referred By ___________________________________
Purpose of this appointment:____
____

Surgeries, serious illness/injury, auto accidents and hospitalizations:

Incident____Month/Year_______
Incident____Month/Year_______
Incident____Month/Year_______
Incident____Month/Year_______
Incident____Month/Year_______

*List medications:*____
____
____

List herbs/vitamins:____
____
____

Family history: List diseases, health problems and causes of death.

Father _______________ Grandmother____________ Grandfather ___________
Mother ______________ Grandmother____________ Grandfather_____________
Siblings_________________________ Children _____________________________

Imaging: Include CT scan, MRI, X-Ray, Dental

Date __________Type____________ Location ___________ Findings __________
Date __________Type____________ Location ___________ Findings __________
Date __________Type____________ Location ___________ Findings __________

Rolls / Relationships:

Marital Status: __ Single __ Married __ Divorced __Long Term Partnership __ Widow/er

Additional Persons in your Household? ____

Child's Name	Age	Gender

Health Questions:

Do you wake up to urinate during the night?_____ if yes, How many times? _____

Do you have at least 2 bowl movements a day?_____ if not how many?______

How many ounces of water do you drink per day?______

Do you drink coffee/tea?______ soda?______ alcohol?_______

Do you eat fried food?____ packaged foods?____ fast food?_____ sweets? ____

Do you follow an eating program?____

Do you follow an exercise program?_______________________________________

How is your energy on a daily basis?______________________________________

Do you get angry quickly? ___ Do you get weepy? ___ Are you a workaholic?___

Female History: Onset age___ Are you regular? _________ # days of flow? ____

Light/med/heavy? ____ #Pregnancies?_____#Births? _____ Birth control? _____

Hormones? _______ Depression? ___ Mood swings? ___ Breast tenderness?___

Stress / Coping:

Have you ever sought counseling? Yes No Describe: __________________________

Are you currently in Therapy? Yes No Describe: _____________________________

Do you feel you have an excess amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

How do you deal with stress? ____

Daily Stressors: Rate on a scale of 1-10. Work ___ Family ___ Social ___ Finances ___ Health ___ Other ___

Do you practice Meditation or Relaxation Techniques. Yes No How often? ________

Circle all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer

Other:____

Have you been Abused, a victim of a crime, or experienced significant trauma? Yes No

if yes, please explain____

Do you regularly give gratitude for everything in your life? Yes No
How would you describe your overall attitude towards life? ___________________
Do you have a spiritual practice? ____
Resources for Emotional Support: circle all that apply
Spouse Family Friends Religious/Spiritual Pets Other _____________________

Sleep / Rest:
Average number of hours you sleep at night? __________
What time do you typically go to sleep? ____ Do You have trouble going to sleep?____
Do you feel rested upon awakening? _____ Do you have problems with insomnia?____
Do you snore? ____ Do you use sleep aids? ____ if yes, what kind? _______________

How have things been going for you?	Very Well	Fine	Poorly	Does Not apply
Overall				
At School				
In your Job				
In your social life				
With sex				
With your attitude				
With your boyfriend/ girlfriend				
With your Children				
With your parents				
With your Spouse				

Patient Agreement
Payment is due at time of service. No insurance is accepted. We accept Cash, Credit Cards, and Personal Checks. Cancellations must be made by 10AM the previous day by phone to avoid full charge. I understand to achieve my treatment objectives, it is imperative to comply with all instructions.

Signature__________________________________ Date ____________________