NorthPointe Medicine, P.C.

Patient Information

Name: _____ Today's Date: _____

❑ Male ❑ Female: Date of Birth: _____ Age: _____ Blood Type: _____

Phone: Home# _____ Work# _____ Cell# _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address:_____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed Partner's Name: _____

Occupation: _____Employer: _____

_____ Work# _____ Cell# _____

Consent and Agreement of Financial Responsibility

I, _____ the undersigned, agree to payment for services as they are rendered.

Please kindly give 24 hr advance notice if you cannot keep your appointment. Your prompt notice of cancellation allows others to be seen.

I hereby request and consent to a Zoom virtual Functional Medicine evaluation, for education, guidance, support and recommendations to facilitate my healing by Dr. Barbara Maddoux, RN, DOM, IFMCP. I understand my initial 1 hour virtual visit will be prepaid at the time the consult is scheduled. I understand specific results are not promised or implied and no specific outcome is guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment. I agree to hold Dr. Barbara Maddoux harmless.

I acknowledge that the nature of Functional Medicine may require follow-up evaluation to review treatment protocols, lab results, and progress on my healing path. When this occurs I will request a 15 or 30 minute follow up session.

I hereby Consent to evaluation and consultation and agree to the above statement of financial responsibility.

Patient Signature: _____Date: _____

How did you hear about our Dr. Maddoux?_____

Main problem you would like help with? _____

How long have you had this problem? _____

To what extent does this problem interfere with your daily activities? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

If you have had any lab work done in the last 12 months please provide copies:

_____

What other treatments have you tried, and what has been your response? _____

_____

What kind of nutritional changes would you be willing to make for your health? _____

_____

DIET - PERSONAL HABITS

Height: Current: _____ft _____in 1 year ago: Same or _____ft _____in

Weight: Current: _____lbs 1 year ago: _____lbs

Briefly describe a typical day's meals:

Breakfast _____

Lunch _____

Dinner _____

How many servings of fruits and vegetables do you eat every day? _____

Do you diet or restrict your food intake? ❑ No ❑ Yes - if yes please explain _____

Do you have a regular exercise program? ❑ No ❑ Yes - if yes please explain _____

Do you smoke? ❑ No ❑ Yes - if yes, how much/often? _____

Do you drink alcoholic beverages ❑ No ❑ Yes - if yes, how much/often? _____

Do you drink coffee, or other caffeinated beverages? ❑ No ❑ Yes - if yes, how much/often? _____

Please list any allergies (medication, food, or environmental) you may have:

_____

_____

List any medications, vitamins, hormones, homeopathics, laxatives, herbs, or other supplements you are taking. Please include doses and how often you take them. **(Attach a separate sheet if needed)**

_____

_____

PAST MEDICAL HISTORY

Please indicate if you have/have had any of these significant illnesses and the date of occurrence.

_____ Cancer	_____ Diabetes	_____ Heart Disease
_____ High Blood Pressure	_____ Hepatitis	_____ Respiratory Disease
_____ Rheumatic Fever	_____ Seizures	_____ Thyroid Disease
_____ Alcohol/Drug Addiction	_____ Other:_____	

FAMILY MEDICAL HISTORY

Please circle and indicate which family member has had any of the following.

_____ Alcoholism	_____ Asthma	_____ Autoimmune Disorders
_____ Cancer (type _____)		_____ Diabetes
_____ Heart Disease	_____ Seizures	_____ Stroke

Please check if you have experienced any of the following in the last 3 months

GENERAL

_____ Head or chest cold	_____ Localized Weakness	_____ Sudden Energy Drop
_____ Flu	_____ Fevers or chills	_____ Sweat easily
_____ Easy to bleed or bruise	_____ Peculiar tastes or smells	_____ Fatigue easily
_____ Strong Thirst	_____ Poor sleeping	_____ Always fatigued
_____ Tremor	_____ Poor balance	_____ Weight loss
_____ Night sweats	_____ Cravings	_____ Weight gain
_____ No thirst	_____ Puffiness or swelling	_____ Other

SKIN AND HAIR

_____ Rashes	_____ Itching	_____ Dandruff
_____ Skin ulcers	_____ Eczema	_____ Hair loss
_____ Hives	_____ Pimples	_____ Recent moles

HEAD, EYES, NOSE AND THROAT

_____ Glasses	_____ Dizziness	_____ Sinus Problems
_____ Poor Vision	_____ Ear Ringing	_____ Nose Bleeds
_____ Cataracts	_____ Poor hearing/hearing loss	_____ Teeth grinding
_____ Eye Strain	_____ Ear aches	_____ Teeth problems
_____ Night blindness	_____ Headaches	_____ Gum problems
_____ Blurry vision	_____ Concussions	_____ Recurrent sore throat
_____ Eye pain	_____ Facial pain	_____ Lip/tongue sores
_____ Color blindness	_____ Jaw click	_____ Sore throat
_____ Spots in front of eyes	_____ Migraines	_____ Other
_____ Dental Amalgam Fillings	_____ Root Canals	

CARDIOVASCULAR

_____ High blood pressure	_____ Low blood pressure	_____ Heart murmur
_____ Cold hands or feet	_____ Blood clots	_____ Irregular heartbeat
_____ Swelling of hands	_____ Phlebitis	_____ Palpitations
_____ Swelling of feet	_____ Fainting	_____ Light headedness
_____ Angina/chest pain	_____ Varicose veins	_____ High cholesterol

RESPIRATORY

_____	Dry cough	_____	Bronchitis	_____	Difficulty breathing
_____	Cough/Phlegm	_____	Coughing up blood	_____	Pneumonia
_____	Shortness of breath	_____	Painful breathing	_____	Emphysema
_____	Asthma	_____	Wheezing	_____	Other
_____	Asthma, worse on exertion				

GASTROINTESTINAL

_____	Nausea	_____	Constipation	_____	Diarrhea
_____	Bad breath	_____	Black Stools	_____	Abdominal pain
_____	Vomiting	_____	Chronic laxative use	_____	Intestinal gas
_____	Indigestion	_____	Blood in stools	_____	Belching
_____	Decreased appetite	_____	Rectal pain	_____	Jaundice
_____	Excessive appetite	_____	Hemorrhoids		
_____	Other changes in appetite			_____	Other _____

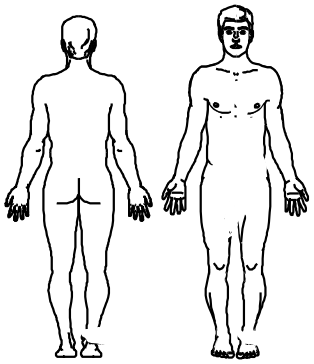
GENITOURINARY

_____	Difficult urination	_____	Urgency to urinate	_____	Blood in urine
_____	Painful urination	_____	Frequent urination	_____	Herpes
_____	Decrease in urine flow	_____	Kidney stones	_____	Low sexual energy
_____	Cloudy urine	_____	Frequent night urination	_____	Excess sexual energy
_____	Genital sores	_____	Unable to hold urine	_____	Other _____

MUSCULOSKELETAL PAIN OR DISCOMFORT – PLEASE INDICATE LOCATION ON DIAGRAM TO THE RIGHT

The following best describes the nature of these pains. . . .

——	Sharp	——	Empty	——	Worse when humid
——	Dull	——	Tight	——	Worse when dry
——	Throbbing	——	Heavy	——	Worse when hot
——	Distending	——	Moving	——	Worse when cold
——	Cramping	——	Worse at night	——	Aggravated by diet
——	Burning	——	Worse during the day	——	Worse with stress
				——	Other _____



Please mark areas of pain

If the pain is due to an injury, or you know the cause of the pain, please explain. _____

_____

Is there anything that makes you feel better? _____

Please list your past surgeries or major injuries and their dates: _____

_____

GYNECOLOGY – PREGNANCY

_____	Irregular period	_____	Painful periods	_____	Vaginal discharge
_____	Vaginal sores	_____	Clots	_____	Premature births
_____	Abortions	_____	Miscarriages	_____	PMS
_____	Heavy flow	_____	Light flow	_____	Spotting

Age at 1st menses _____ Number of live births _____

Date of last menses _____ Complications? _____

Duration of menses (days) _____ Current birth control method _____

Number of days from 1st day of menses to 1st day next menses _____

NEURO-PSYCHOLOGICAL

_____	Seizures	_____	Numb body areas	_____	Concussion
_____	Twitches	_____	Lack of coordination	_____	Depression
_____	Bad temper	_____	Loss of balance	_____	Stress
_____	Poor memory	_____	Anxiety	_____	Mood swings
_____	Irritability	_____	Tremors	_____	Other _____

Have you ever been emotionally, physically or sexually abused? _____

Have you recently had unusually stressful experiences, such as; divorce, death of a loved one, birth, marriage, bankruptcy, job loss, illness, injury)? _____

Is there constant stress in your life? _____

Do you use any recreational drugs? ❑ No ❑ Yes - if yes, how much/often? _____

Is there anything else you would like to discuss or comment about? _____

_____

_____

Have you ever had any of the following? If yes, please explain.

Vaccinations_____ Frequent Tylenol use_____

Antibiotics_____ Blood transfusions_____

Aspartame intake – (Equal, diet soda)_____ High fish intake (large, predatory)_____

Heavy metal exposure_____ Chemical exposure_____

Pesticide exposure in home_____ Tick bite history (rash, joint pain)_____

Well water consumption _____ Travel history_____

Pets with infections, illness_____ Mold exposure in home or workplace_____

Electrical overexposure – high tension wire, _____

work place, etc_____