Sandpoint Super Drug Functional Medicine Patient Intake Packet

(Male & Female)
Patient Name: ______________________
Date of Birth: _____________ Age: ____
Phone: _________________________
Email: _________________________
Address: ________________________
Primary Care Physician: _______________
Emergency Contact: __________________
Phone: _________________________

1. Chief Complaint / Reason for Visit

What is the **main reason for your visit today?**

____

____

List your **top three health concerns**

Concern When did it begin? Severity (1–10)

1

2

3

2. History of Present Illness

When did symptoms begin?

☐ < 3 months

☐ 3–12 months

☐ 1–5 years

☐ > 5 years

Did symptoms begin after any of the following?

☐ Infection (viral or bacterial)

☐ COVID infection

☐ Mold exposure

☐ Major life stress

☐ Surgery or trauma

☐ Medication reaction

☐ Unknown

What **makes symptoms better**?

What **makes symptoms worse**?

How do these symptoms affect your daily life?

3. Functional Medicine Symptom Overview
Check symptoms you currently experience.

Energy / Chronic Fatigue

☐ Persistent fatigue
☐ Post-exertional fatigue
☐ Low stamina
☐ Unrefreshing sleep
☐ Energy crashes

Brain / Neurologic

☐ Brain fog
☐ Difficulty concentrating
☐ Memory problems
☐ Headaches
☐ Dizziness
☐ Tingling or numbness

Immune / Autoimmune

☐ Joint pain
☐ Muscle aches
☐ Chronic inflammation
☐ Recurrent infections
☐ Swollen lymph nodes
☐ Sensitivity to chemicals

Digestive / Gut Health

☐ Bloating
☐ Gas
☐ Constipation

☐ Diarrhea
☐ Food sensitivities
☐ Heartburn / reflux
☐ Abdominal pain

Hormones
☐ Low libido
☐ Erectile dysfunction
☐ Irregular menstrual cycles
☐ Menopause symptoms
☐ Thyroid symptoms

Metabolic
☐ Weight gain
☐ Difficulty losing weight
☐ Blood sugar problems
☐ High cholesterol

4. Mold Illness Screening
Have you lived or worked in a building with:
☐ Water damage
☐ Visible mold
☐ Mold odor
☐ Flooding history
Do you feel worse in certain buildings?
☐ Yes
☐ No
Symptoms triggered by buildings may include:
☐ Headaches
☐ Fatigue
☐ Brain fog
☐ Sinus congestion
☐ Respiratory symptoms
Do symptoms improve when leaving the environment?
☐ Yes
☐ No

5. Autoimmune Disease Screening

Have you ever been diagnosed with:

☐ Hashimoto's thyroiditis
☐ Graves disease
☐ Rheumatoid arthritis
☐ Lupus
☐ Psoriasis
☐ Celiac disease
☐ Crohn's disease
☐ Ulcerative colitis

Other autoimmune conditions:

Family history of autoimmune disease?

☐ Yes
☐ No

6. Gut Health History

Have you ever been diagnosed with:

☐ IBS
☐ SIBO
☐ Candida overgrowth
☐ Parasites
☐ Leaky gut syndrome
☐ Food allergies

History of:

☐ Chronic constipation
☐ Chronic diarrhea
☐ Gallbladder removal
☐ Food intolerance

Have you taken **multiple courses of antibiotics?**

☐ Yes
☐ No

7. Environmental Exposure History

Exposure to:

☐ Mold or water damage
☐ Pesticides
☐ Industrial chemicals
☐ Heavy metals
☐ Tick bites / Lyme disease

Current home environment:

☐ New home
☐ Older home
☐ Recent renovations
☐ Possible mold exposure

8. Past Medical History

Check any conditions you have had.

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Thyroid disorder
☐ Heart disease
☐ Sleep apnea
☐ Cancer
☐ Depression or anxiety

Other conditions:

____

____

9. Surgeries / Hospitalizations

Surgery or Procedure Year

____

10. Current Medications

Medication Dose Reason

____

11. Supplements

Supplement Dose Reason

____

12. Lifestyle Overview

Sleep

Average hours per night: _____

☐ Restful

☐ Frequent waking

☐ Insomnia

Exercise

☐ None

☐ Light activity

☐ Moderate exercise

☐ Regular exercise

Diet Pattern

☐ Standard American diet

☐ Low carb / ketogenic

☐ Paleo

☐ Mediterranean

☐ Vegetarian

Typical daily diet:

____

____

13. Family History

Family members with:

☐ Heart disease

☐ Diabetes

☐ Cancer

☐ Autoimmune disease

☐ Thyroid disease

☐ Dementia

14. Health Goals

What are your **top goals for your health?**

☐ Improve energy

☐ Reduce inflammation

☐ Improve gut health

☐ Optimize hormones
☐ Weight loss
☐ Longevity / disease prevention
Describe your goals:

When was the **last time you felt well?**

What do you think is contributing to your illness?

HIPPA Acknowledgement and Consent Form

Purpose of Consent: I understand that I have certain rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA). By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. The notice describes how we may use and disclose your protected health information and other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
You may obtain a copy of our Notice of Privacy Practices at any time by contacting: **208-263-1408 Sandpoint Super Drug Clinical Services 604 North 5th Ave Sandpoint, Idaho 83864.**
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the above contact person. Revocation of this consent will not affect any action we took in reliance of this consent prior to receiving your revocation.
Signature: I have had the opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient Signature: Date: