

## Integrative Lyme Center of Rhode Island, LLC

Treatment of chronic diseases and symptoms

### FUNCTIONAL MEDICINE QUESTIONNAIRE

Our ability to draw effective conclusions about your health, and how to improve it, depends on your ability to respond thoughtfully and accurately to these questions, and those posed by Donna during your consultation. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with them. Your careful consideration to each of the following questions will enhance our efficiency and provide for more effective use of your scheduled consultation time. These questions will help identify underlying causes of illness, and assist us to formulate a treatment plan.

|                                   |                                  |                          |
|-----------------------------------|----------------------------------|--------------------------|
| First Name: _____                 | Middle Name: _____               | Last Name: _____         |
| Address: _____                    | City: _____                      | State: _____ ZIP: _____  |
| Email: _____                      |                                  |                          |
| Home Phone:(_____) _____ - _____  | Birth Date: ____/____/____       | Age: _____               |
| Cell Phone: (_____) _____ - _____ | month day year                   |                          |
| Work Phone:(_____) _____ - _____  | Place of Birth: _____            |                          |
| Occupation: _____                 | City or town & country if not US |                          |
| Referred by: _____                | Height: ____' ____"              | Weight: _____ Sex: _____ |
| Today's Date _____                |                                  |                          |

1. Please check appropriate box(es):

- |   |                                    |  |                                |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

If we had a magic wand, and could change three things about your current condition, what would they be?

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2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

| DESCRIBE PROBLEM                | MILD/<br>MODERATE/<br>SEVERE | TREATMENT<br>APPROACH | SUCCESS  |
|---------------------------------|------------------------------|-----------------------|----------|
| <b>Example:</b> Post Nasal Drip | Moderate                     | Elimination Diet      | Moderate |
| a.                              |                              |                       |          |
| b.                              |                              |                       |          |
| c.                              |                              |                       |          |
| d.                              |                              |                       |          |
| e.                              |                              |                       |          |
| f.                              |                              |                       |          |
| g.                              |                              |                       |          |

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
 Example: Wendy, age 7, sister

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4. Do you have any pets or farm animals? Yes\_\_\_\_ No\_\_\_\_  
 If yes, where do they live? 1. \_\_\_\_\_ indoors 2. \_\_\_\_\_ outdoors 3. \_\_\_\_\_ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes\_\_\_\_ No\_\_\_\_  
 If so, when and where?

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6. Have you or your family recently experienced any major life changes? Yes\_\_\_\_ No\_\_\_\_  
 If yes, please comment:

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7. Have you experienced any major losses in life? Yes\_\_\_\_ No\_\_\_\_  
 If so, please comment:

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8. How important is religion (or spirituality) for you and your family's life?

- a. \_\_\_\_\_ not at all important
- b. \_\_\_\_\_ somewhat important
- c. \_\_\_\_\_ extremely important

9. How much time have you lost from work or school in the past year?

- a. \_\_\_\_\_ 0-2 days
- b. \_\_\_\_\_ 3 -14 days
- c. \_\_\_\_\_ > 15 days

10. Previous jobs:

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?  
 Yes       No
- b. Have you been involved in abusive relationships in your life?  
 Yes       No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?  
 Yes       No
- d. Do you currently feel safe in your home?  
 Yes       No
- e. Do you feel safe, respected and valued in your current relationships?  
 Yes       No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?  
 Yes       No
- g. Would you feel safer discussing any of these issues privately?  
 Yes       No

12. Past Medical and Surgical History:

| ILLNESSES                              | WHEN | COMMENTS |
|--|------|----------|
| a. Anemia                              |      |          |
| b. Arthritis                           |      |          |
| c. Asthma                              |      |          |
| d. Bronchitis                          |      |          |
| e. Cancer                              |      |          |
| f. Chronic Fatigue Syndrome            |      |          |
| g. Crohn's Disease, Ulcerative Colitis |      |          |
| h. Diabetes                            |      |          |
| i. Emphysema                           |      |          |
| j. Epilepsy, convulsions, or seizures  |      |          |
| k. Gallstones                          |      |          |
| l. Gout                                |      |          |

Adult Medical Questionnaire

|                         |  |             |                 |
|-------------------------|--|-------------|-----------------|
| m.                      | Heart attack/Angina                          |             |                 |
| n.                      | Heart failure                                |             |                 |
| o.                      | Hepatitis                                    |             |                 |
| p.                      | High blood fats (cholesterol, triglycerides) |             |                 |
| q.                      | High blood pressure (hypertension)           |             |                 |
| r.                      | Irritable bowel                              |             |                 |
| s.                      | Kidney stones                                |             |                 |
| t.                      | Mononucleosis                                |             |                 |
| u.                      | Pneumonia                                    |             |                 |
| v.                      | Rheumatic fever                              |             |                 |
| w.                      | Sinusitis                                    |             |                 |
| x.                      | Sleep apnea                                  |             |                 |
| y.                      | Stroke                                       |             |                 |
| z.                      | Thyroid disease                              |             |                 |
| aa.                     | Other (describe)                             |             |                 |
| <b>INJURIES</b>         |  | <b>WHEN</b> | <b>COMMENTS</b> |
| ab.                     | Back injury                                  |             |                 |
| ac.                     | Broken (describe)                            |             |                 |
| ad.                     | Head injury                                  |             |                 |
| ae.                     | Neck injury                                  |             |                 |
| af.                     | Other (describe)                             |             |                 |
| <b>DIAGNOSTIC TESTS</b> |  | <b>WHEN</b> | <b>COMMENTS</b> |
| ag.                     | Barium Enema                                 |             |                 |
| ah.                     | Bone Scan                                    |             |                 |
| ai.                     | CAT Scan of Abdomen                          |             |                 |
| aj.                     | CAT Scan of Brain                            |             |                 |
| ak.                     | CAT Scan of Spine                            |             |                 |
| al.                     | Chest X-ray                                  |             |                 |
| am.                     | Colonoscopy                                  |             |                 |
| an.                     | EKG  |             |                 |
| ao.                     | Liver scan                                   |             |                 |
| ap.                     | Neck X-ray                                   |             |                 |
| aq.                     | NMR/MRI                                      |             |                 |
| ar.                     | Sigmoidoscopy                                |             |                 |
| as.                     | Upper GI Series                              |             |                 |
| at.                     | Other (describe)                             |             |                 |

|                   |             |                 |
|-------------------|-------------|-----------------|
| <b>OPERATIONS</b> | <b>WHEN</b> | <b>COMMENTS</b> |
|-------------------|-------------|-----------------|

|     |                  |  |  |
|-----|------------------|--|--|
| au. | Appendectomy     |  |  |
| av. | Dental Surgery   |  |  |
| aw. | Gall Bladder     |  |  |
| ax. | Hernia           |  |  |
| ay. | Hysterectomy     |  |  |
| az. | Tonsillectomy    |  |  |
| ba. | Other (describe) |  |  |
| bb. | Other (describe) |  |  |

13. Hospitalizations:

| WHERE HOSPITALIZED | WHEN | FOR WHAT REASON |
|--------------------|------|-----------------|
| a.                 |      |                 |
| b.                 |      |                 |
| c.                 |      |                 |
| d.                 |      |                 |
| e.                 |      |                 |

14. How often have you taken antibiotics?

|                    | < 5 times | > 5 times |
|--------------------|-----------|-----------|
| Infancy/ Childhood |           |           |
| Teen               |           |           |
| Adulthood          |           |           |

15. How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

|                    | < 5 times | > 5 times |
|--------------------|-----------|-----------|
| Infancy/ Childhood |           |           |
| Teen               |           |           |
| Adulthood          |           |           |

16. What medications are you taking now? Include non-prescription drugs, and please continue on the back of this sheet, if needed.

| Medication Name | Date started | Dosage |
|-----------------|--------------|--------|
| 1.              |              |        |
| 2.              |              |        |
| 3.              |              |        |
| 4.              |              |        |
| 5.              |              |        |
| 6.              |              |        |
| 7.              |              |        |
| 8.              |              |        |

17. Are you allergic to any medications?

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please list:

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18. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible. Please bring all supplements and medications to the office on your first appointment. Please continue the list on the back of this sheet, if more room is needed.

| Vitamin/Mineral/Supplement Name | Date started | Dosage |
|---------------------------------|--------------|--------|
| 1.                              |              |        |
| 2.                              |              |        |
| 3.                              |              |        |
| 4.                              |              |        |
| 5.                              |              |        |
| 6.                              |              |        |
| 7.                              |              |        |
| 8.                              |              |        |

19. Childhood:

| Question   | Yes | No | Don't Know | Comment |
|--|-----|----|------------|---------|
| 1. Were you a full term baby?                          |     |    |            |         |
| a. A preemie?  |     |    |            |         |
| b. Breast fed?   |     |    |            |         |
| c. Bottle fed?   |     |    |            |         |
| 2. As a child did you eat a lot of sugar and/or candy? |     |    |            |         |

20. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes\_\_\_\_ No\_\_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

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Place a check mark next to the food/drink that applies to your current diet.

|    |                        |   |    |                    |   |    |                     |   |
|----|------------------------|---|----|--------------------|---|----|---------------------|---|
|    | <b>Usual Breakfast</b> | √ |    | <b>Usual Lunch</b> | √ |    | <b>Usual Dinner</b> | √ |
| a. | None                   |   | a. | None               |   | a. | None                |   |

Adult Medical Questionnaire

|    |                     |  |    |                     |  |    |                     |  |
|----|---------------------|--|----|---------------------|--|----|---------------------|--|
| b. | Bacon/Sausage       |  | b. | Butter              |  | b. | Beans (legumes)     |  |
| c. | Bagel               |  | c. | Coffee              |  | c. | Brown rice          |  |
| d. | Butter              |  | d. | Eat in a cafeteria  |  | d. | Butter              |  |
| e. | Cereal              |  | e. | Eat in restaurant   |  | e. | Carrots             |  |
| f. | Coffee              |  | f. | Fish sandwich       |  | f. | Coffee              |  |
| g. | Donut               |  | g. | Juice               |  | g. | Fish                |  |
| h. | Eggs                |  | h. | Leftovers           |  | h. | Green vegetables    |  |
| i. | Fruit               |  | i. | Lettuce             |  | i. | Juice               |  |
| j. | Juice               |  | j. | Margarine           |  | j. | Margarine           |  |
| k. | Margarine           |  | k. | Mayo                |  | k. | Milk                |  |
| l. | Milk                |  | l. | Meat sandwich       |  | l. | Pasta               |  |
| m. | Oat bran            |  | m. | Milk                |  | m. | Potato              |  |
| n. | Sugar               |  | n. | Salad               |  | n. | Poultry             |  |
| o. | Sweet roll          |  | o. | Salad dressing      |  | o. | Red meat            |  |
| p. | Sweetener           |  | p. | Soda                |  | p. | Rice                |  |
| q. | Tea                 |  | q. | Soup                |  | q. | Salad               |  |
| r. | Toast               |  | r. | Sugar               |  | r. | Salad dressing      |  |
| s. | Water               |  | s. | Sweetener           |  | s. | Soda                |  |
| t. | Wheat bran          |  | t. | Tea                 |  | t. | Sugar               |  |
| u. | Yogurt              |  | u. | Tomato              |  | u. | Sweetener           |  |
| v. | Other: (List below) |  | v. | Water               |  | v. | Tea                 |  |
|    |                     |  | w. | Yogurt              |  | w. | Water               |  |
|    |                     |  | x. | Other: (List below) |  | x. | Yellow vegetables   |  |
|    |                     |  |    |                     |  | y. | Other: (list below) |  |

21. How much of the following do you consume each week?

|    |                                      |  |
|----|--------------------------------------|--|
| a. | Candy                                |  |
| b. | Cheese                               |  |
| c. | Chocolate                            |  |
| d. | Cups of coffee containing caffeine   |  |
| e. | Cups of decaffeinated coffee or tea  |  |
| f. | Cups of hot chocolate                |  |
| g. | Cups of tea containing caffeine      |  |
| h. | Diet sodas                           |  |
| i. | Ice cream                            |  |
| j. | Salty foods                          |  |
| k. | Slices of white bread (rolls/bagels) |  |
| l. | Sodas with caffeine                  |  |
| m. | Sodas without caffeine               |  |

22. Are you on a special diet?

\_\_\_\_\_ ovo-lacto  
\_\_\_\_\_ diabetic

\_\_\_\_\_ vegetarian  
\_\_\_\_\_ vegan

Yes\_\_\_\_\_ No\_\_\_\_\_  
\_\_\_\_\_ other (describe):

\_\_\_\_\_





If yes, when? \_\_\_\_\_Spring \_\_\_\_\_Fall \_\_\_\_\_ Summer \_\_\_\_\_Winter

41. Have you been exposed to toxic metals in your job or at home? Yes\_\_\_\_ No\_\_\_\_ Don't Know\_\_\_\_

If yes, which one(s)? \_\_\_\_\_lead \_\_\_\_\_cadmium  
 \_\_\_\_\_arsenic \_\_\_\_\_mercury  
 \_\_\_\_\_aluminum

42. Do odors affect you? Yes\_\_\_\_ No\_\_\_\_

43. Hobbies and leisure activities:

\_\_\_\_\_

\_\_\_\_\_

44. How well have things been going for you?

|                                   | Very Well | Fair | Poorly | Very Poorly | Does not apply |
|-----------------------------------|-----------|------|--------|-------------|----------------|
| a. At school                      |           |      |        |             |                |
| b. In your job                    |           |      |        |             |                |
| c. In your social life            |           |      |        |             |                |
| d. With close friends             |           |      |        |             |                |
| e. With sex                       |           |      |        |             |                |
| f. With your attitude             |           |      |        |             |                |
| g. With your boyfriend/girlfriend |           |      |        |             |                |
| h. With your children             |           |      |        |             |                |
| i. With your parents              |           |      |        |             |                |
| j. With your spouse               |           |      |        |             |                |

45. Have you ever had psychotherapy or counseling? Yes\_\_\_\_ No\_\_\_\_

Currently? \_\_\_\_\_ Previously? \_\_\_\_\_ If previously, from \_\_\_\_\_ to \_\_\_\_\_.

What kind?

\_\_\_\_\_

Comments:

\_\_\_\_\_

46. Are you currently, or have you ever been, married? Yes\_\_\_\_ No\_\_\_\_

If so, when were you married? \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
When were you separated? \_\_\_\_\_ Never \_\_\_\_\_  
When were you divorced? \_\_\_\_\_ Never \_\_\_\_\_  
When were you remarried? \_\_\_\_\_ Never \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
Comments: \_\_\_\_\_

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47. Do you exercise regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, how many times a week?

- 1. \_\_\_\_\_ 1x
- 2. \_\_\_\_\_ 2x
- 3. \_\_\_\_\_ 3x
- 4. \_\_\_\_\_ 4x or more

When you exercise, how long is each session?

- 1. \_\_\_\_\_ ≤15 min
- 2. \_\_\_\_\_ 16-30 min
- 3. \_\_\_\_\_ 31-45 min
- 4. \_\_\_\_\_ > 45 min

What type of exercise is it?

- |                       |                    |
|-----------------------|--------------------|
| _____ jogging/walking | _____ tennis       |
| _____ basketball      | _____ water sports |
| _____ home aerobics   | _____ other        |

48. What is the attitude of those close to you about your illness?

\_\_\_\_\_ Supportive    \_ \_\_\_ Non-supportive

**THIS PAGE IS FOR WOMEN ONLY (questions 48-56):**

49. Have you ever been pregnant? (If no, skip to question 53.) Yes\_\_\_ No\_\_\_  
Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_ Number of preemies \_\_\_\_\_  
Did you develop toxemia (high blood pressure)? Yes\_\_\_ No\_\_\_  
Have you had other problems with pregnancy? Yes\_\_\_ No\_\_\_  
If so, please comment: \_\_\_\_\_  
\_\_\_\_\_

50. Age at first period \_\_\_\_\_ Date of last Pap Smear \_\_\_\_\_ Date of last Mammogram \_\_\_\_\_  
Pap Smear: \_\_\_ Normal \_\_\_ Abnormal  
Mammogram: \_\_\_ Normal \_\_\_ Abnormal

51. Have you ever used birth control pills? Yes\_\_\_ No\_\_\_ If yes, when \_\_\_\_\_

52. Are you taking the pill now? Yes\_\_\_ No\_\_\_

53. Did taking the pill agree with you? Yes\_\_\_ No\_\_\_ Not applicable \_\_\_\_\_

54. Do you currently use contraception? Yes\_\_\_ No\_\_\_  
If yes, what type of contraception do you use? \_\_\_\_\_

55. Are you in menopause? No \_\_\_ Yes \_\_\_ If yes, age at last period \_\_\_\_\_

Do you take: Estrogen?\_\_\_ Ogen?\_\_\_ Estrace?\_\_\_ Premarin?\_\_\_ Other (specify) \_\_\_\_\_  
Progesterone?\_\_\_ Provera? \_\_\_ Other (specify) \_\_\_\_\_

56. How long have you been on hormone replacement therapy?

57. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes\_\_\_ No\_\_\_ Not applicable

Please check if these symptoms occur presently **or** have occurred in the past 6 months.

| <b>GENERAL:</b>               | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|-------------------------------|-------------|-----------------------|---------------|
| Cold hands & feet             |             |                       |               |
| Cold intolerance              |             |                       |               |
| Daytime sleepiness            |             |                       |               |
| Difficulty falling asleep     |             |                       |               |
| Early waking                  |             |                       |               |
| Fatigue                       |             |                       |               |
| Fever                         |             |                       |               |
| Flushing                      |             |                       |               |
| Heat intolerance              |             |                       |               |
| Night waking                  |             |                       |               |
| Nightmares                    |             |                       |               |
| No dream recall               |             |                       |               |
| <b>HEAD, EYES &amp; EARS:</b> |             |                       |               |
| Conjunctivitis                |             |                       |               |
| Distorted sense of smell      |             |                       |               |
| Distorted taste               |             |                       |               |
| Ear fullness                  |             |                       |               |
| Ear noises                    |             |                       |               |
| Ear pain                      |             |                       |               |
| Ear ringing/buzzing           |             |                       |               |
| Eye crusting                  |             |                       |               |
| Eye pain                      |             |                       |               |
| Headache                      |             |                       |               |
| Hearing loss                  |             |                       |               |
| Hearing problems              |             |                       |               |
| Lid margin redness            |             |                       |               |
| Migraine                      |             |                       |               |
| Sensitivity to loud noises    |             |                       |               |
| Vision problems               |             |                       |               |

| <b>MUSCULOSKELETAL:</b> | <b>Mild</b> | <b>Mod-<br/>erate</b> | <b>Severe</b> |
|-------------------------|-------------|-----------------------|---------------|
| Back muscle spasm       |             |                       |               |
| Calf cramps             |             |                       |               |
| Chest tightness         |             |                       |               |
| Foot cramps             |             |                       |               |
| Joint deformity         |             |                       |               |

Adult Medical Questionnaire

|                                 |  |  |  |
|---------------------------------|--|--|--|
| Joint pain                      |  |  |  |
| Joint redness                   |  |  |  |
| Joint stiffness                 |  |  |  |
| Muscle pain                     |  |  |  |
| Muscle spasms                   |  |  |  |
| Muscle stiffness                |  |  |  |
| Muscle twitches:<br>Around eyes |  |  |  |
| Arms or legs                    |  |  |  |
| Muscle weakness                 |  |  |  |
| Neck muscle spasm               |  |  |  |
| Tendonitis                      |  |  |  |
| Tension headache                |  |  |  |
| TMJ problems                    |  |  |  |
| <b>MOOD/NERVES:</b>             |  |  |  |
| Agoraphobia                     |  |  |  |
| Anxiety                         |  |  |  |
| Auditory hallucinations         |  |  |  |
| Black-out                       |  |  |  |
| Depression                      |  |  |  |
| Difficulty:<br>Concentrating    |  |  |  |
| With balance                    |  |  |  |
| With thinking                   |  |  |  |
| With judgment                   |  |  |  |
| With speech                     |  |  |  |
| With memory                     |  |  |  |
| Dizziness (spinning)            |  |  |  |
| Fainting                        |  |  |  |
| Fearfulness                     |  |  |  |
| Irritability                    |  |  |  |
| Light-headedness                |  |  |  |

Is there any other family history we should know about? Yes\_\_\_\_ No\_\_\_\_

If so, please comment:

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## Readiness Assessment

On a scale of 1 - 5, with 5 being very willing, to 1 (not willing) please rate the following questions.

In order to improve your health, how willing are you to:

Significantly modify your diet    5    4    3    2    1

Take several nutritional supplements    5    4    3    2    1

Keep a record of everything you eat each day    5    4    3    2    1

Modify your lifestyle (eg, work demands, sleep habits)    5    4    3    2    1

Practice a relaxation technique    5    4    3    2    1

Engage in regular exercise    5    4    3    2    1

Have periodic lab tests to assess progress    5    4    3    2    1

**Please bring all medications and supplements along with this form to your first appointment**

**Donna Zaken, RN, MSN, APRN**  
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**Providence, RI 02906**  
**401-585-7877**