CENTER FOR
Functional Medicine
& Wellbeing
Empowering you to optimize your health

Dr. Jeffrey G. Donatello

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Email Address: _____
Full Name: _____
Name of Wife, Husband, or Guardian: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: ( ) _____ Cell Phone Number: ( ) _____
Birth Date: _____ Male: _____ Female: _____ Marital Status: S ___ M ___ D ___ W ___
Number of Children: _____ Currently Pregnant? _____
Occupation: _____
Employer's Name/Phone #: _____
Spouse's Occupation/Employer: _____
Name and Phone # of Emergency Contact: _____
How did you hear about our office? _____
Appointment Reminders? ☐ Voice Home ☐ Voice Cell ☐ Text ☐ Email ☐ None

Primary Complaint(s)_____

Present Symptom(s)_____

When Symptoms Started____/____/____ How Symptoms Started_____

Severity of Pain from 1 (mild pain) to 10 (severe pain): _____

What is your pain/condition holding you back from doing (i.e. sleeping, exercising, traveling, time with family, hobbies, eating healthy, etc.)?

_____

List **ALL** medications and supplements you take. (Prescription & over-the-counter, use additional paper if needed)

Drug Name:	Dosage:	How long have you taken & for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Check **ALL** (symptoms/pain) you may have had or do have now:

___ADD/ADHD
___Alcoholism
___Allergy
___Alzheimer's
___Anemia
___Appendicitis
___Asthma
___Arthritis
___Back Pain
___Cancer
___Celiac Disease
___Chronic Fatigue
___Constipation
___Depression
___Diabetes
___Diarrhea
___Eczema
___Emphysema
___Epilepsy/seizures
___Fibromyalgia
___Gall Bladder
___Goiter
___Gout
___Headaches
___Heart Attack
___Heart Disease
___Hepatitis
___High Blood Pressure
___High Cholesterol
___High Blood Sugar
___HIV/AIDS
___Irregular Periods/Cramps
___Irritable Bowel
___Kidney infections/stones
___Low Blood Pressure
___Low Blood Sugar
___Lyme Disease
___Lupus
___Migraine
___Miscarriage
___Multiple Sclerosis
___Neck Pain
___Parkinson's
___Pneumonia
___Raynaud's
___Rheumatoid Arth.
___Ringing in ears
___Sinus infection
___Stroke
___Thyroid Problems
___Ulcers
___Vertigo/Dizziness

Do you consume any of the following? (Leave blank what doesn't apply)

Tobacco products (packs/day) _____ how many years? _____
Alcohol drinks/day _____ how many years? _____

Primary Complaint: _____

When did your complaint first begin? _____

What makes your problem better? _____

_____

What makes your problem worse? _____

_____

Describe the type of pain/symptoms you experience: _____

_____

Where exactly is the complaint area? _____

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Please circle the appropriate number on all questions below.
(0- 3: 0 as the least/never to 3 as the most/always)

Category I

Feeling that bowels do not empty completely	0 1 2 3
Abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting fruits and vegetables	0 1 2 3
Undigested food found in stools	0 1 2 3

Category IV

Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

Category V

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow start in the morning?	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly?	0 1 2 3
Afternoon headaches	0 1 2 3

Category VI

Crave sweets during that day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3

Category VII

Tired/sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Outer third of eyebrows thin	0 1 2 3
Thinning of hair on scalp, face, or genitals, or	0 1 2 3
Excessive hair loss	0 1 2 3
Mental sluggishness	0 1 2 3

Category VIII

Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional	0 1 2 3
Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category IX

Do you experience vertigo or dizziness?	Yes No
Difficulty with balance?	Yes No
Difficulty concentrating?	Yes No
Short-term memory loss?	Yes No
Driving causes fatigue/headaches?	Yes No
Computer work causes fatigue/headaches?	Yes No
Has your handwriting changed in recent years?	Yes No

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Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes _____ No _____

I fully understand that my signature is consent and authorization to be examined by Dr. Jeffrey Donatello.

Patient Signature _____ Date: _____