MILLSAcupuncture, Functional Medicine & Herbs

Brief Health Assessment

Please complete and return to Dr. Mills prior to your scheduled telephone health review.

Personal Information

First name

Last name

Date of birth

Gender

Email:

Reason for consultation:

Health & Medical History

Current Health & Medical History:

Check all that Apply

- ☐ Addiction (coffee/cigarettes/ sugar/ alcohol or other substances)
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Anxiety / Depression / Mood swings
- ☐ Asthma
- ☐ Autoimmune Condition (specify type below)
- ☐ Pre-Diabetes Diabetes
- ☐ Diabetes
- ☐ Cancer (specify type below)
- ☐ Celiac disease
- ☐ Gluten intolerance
- ☐ Chronic fatigue syndrome/SEID
- ☐ Eating Disorder (specify below)
- ☐ Fibromyalgia
- ☐ Food allergies or Intolerances
- ☐ GI Condition (specify below)
- ☐ GERD, Heartburn, Hiatal Hernia
- ☐ Headaches
- ☐ Heart condition
- ☐ High blood pressure / hypertension
- ☐ ADHD
- ☐ Environmental Allergies
- ☐ High cholesterol
- ☐ IBD
- ☐ Crohn's
- ☐ Ulcerative colitis
- ☐ Infertility
- ☐ IBS (specify type below)
- ☐ Memory concerns
- ☐ MCI
- ☐ Menopause
- ☐ Neurological Disease (specify below)
- ☐ Obesity
- ☐ Overweight
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Physical limitation (specify below)
- ☐ PMS
- ☐ Prostate
- ☐ Sexual dysfunction

Past Health & Medical History:

Check all that Apply

- ☐ Addiction (coffee/cigarettes/ sugar/ alcohol or other substances)
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Anxiety / Depression / Mood swings
- ☐ Asthma
- ☐ Autoimmune Condition (specify type below)
- ☐ Pre-Diabetes Diabetes
- ☐ Diabetes
- ☐ Cancer (specify type below)
- ☐ Celiac disease
- ☐ Gluten intolerance
- ☐ Chronic fatigue syndrome/SEID
- ☐ Eating Disorder (specify below)
- ☐ Fibromyalgia
- ☐ Food allergies or Intolerances
- ☐ GI Condition (specify below)
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- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Physical limitation (specify below)
- ☐ PMS
- ☐ Prostate
- ☐ Sexual dysfunction

Digestive Function:

- ◯ Good
- ◯ Fair
- ◯ Poor

Bowel Movements

- ◯ Daily
- ◯ < 1x day
- ◯ 1-2x day
- ◯ Diarrhea
- ◯ Constipation
- ◯ Other

If "Other", please specify

Urination

- ◯ 1-2x day
- ◯ 3-5x day
- ◯ > 5-10x day
- ◯ Light Yellow
- ◯ Dark Yellow
- ◯ Other

If "Other", please specify

Signs & Symptom Related to Your Health Concern:

Rate your Typical energy level:

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

Medications/Supplements

Include vitamins, minerals, herbs, medical foods, etc.

Medication/Supplement	Dosage	Frequency	

Measurements

Height:		Current Weight:	
Weight, 1 yr ago:		Lowest adult weight:	
Highest adult weight:		Desired weight:	

Comments:

Exercise/Activity: ○ Yes ○ No

Why not?

Type:

How often?

How long?

Sleep:

- ○ 8+ hours
- ○ 6-8 hours
- ○ <6 hours

Sleep Quality:

- ◯ Good
- ◯ Fair
- ◯ Poor

Life stressors:

- ☐ Work
- ☐ Family
- ☐ Finances
- ☐ Health
- ☐ Relationship/ friendships
- ☐ Other

What do you do to relax?

Comments:

Diet & Food Habits

Do you follow a particular diet/eating pattern? ◯ Yes ◯ No

Diet/eating pattern:

- ☐ Vegan
- ☐ Vegetarian
- ☐ Low carb
- ☐ Ketogenic
- ☐ Paleo
- ☐ Gluten Free
- ☐ Elimination Diet
- ☐ Other

Comments:

Are you aware of any adverse food reactions (allergies/intolerances)? ◯ Yes ◯ No

If yes, explain:

Additional Comments