

# **Welcome to Our Functional Wellness Program**

**We are excited that you have chosen us to help you in the overall improvement of your health!**

Welcome to our **Functional Wellness Program**. The purpose of your consultation-evaluation appointment is to **determine your primary functional needs** and your **personal goals**. Additional testing such as lab work may be recommended to help determine any underlying dysfunction you may be experiencing.

It is **VERY IMPORTANT** that you are punctual for your appointments, and that any and all **paperwork is completed** before your scheduled appointment time. Typically, your first appointment will be 45 minutes in length. Interim office visits are an average of 25 minutes.

In the event additional time is needed, you will be scheduled for another visit. If you need to cancel an appointment, please do so at least 24 hours in advance. If you have any questions or concerns, please **don't hesitate to call**, and you will have an answer within a timely manner.

Again, **welcome and thank you** for having confidence in us. We will do our very best to see that your health care goals are met.

*Dr. Tony Rump D.C., QN CP*

**Lost Creek Chiropractic and Wellness  
3021 Harding Hwy. Suite D  
Lima, Ohio 45804**

NOTICE OF UNDERSTANDING AND AGREEMENT:

I hereby, attest to the following:

1. I fully understand that the Functional Wellness Consultant I am seeing in this office is not a medical physician, and I am not consulting for medical, diagnostic, or treatment procedures.
2. The services performed by the Functional Wellness Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that as a Functional Wellness Consultant the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or Prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Witnessed by \_\_\_\_\_

**Functional Wellness Patient Intake Form**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Phone #: \_\_\_\_\_ Can we leave a message at this number? Y / N

E-mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status (circle): Single Married Partnered Separated Divorced Widow(er)

Children: Y N Number of Children: \_\_\_ Age(s): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

List all surgeries, hospitalizations, or major accidents including date occurred:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Blood Type: \_\_\_\_\_

Have you ever had any infectious diseases from which you never fully recovered? Y N

Have you ever taken antibiotics for a prolonged period of time? \_\_\_\_\_

Prescription Medications	Dose	Since	Adverse Effects?
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supplement/OTC Med _____ Brand	Dose/Frequency _____
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_____	_____
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you use any of the following?

Cigarettes or tobacco: \_\_\_\_\_ Y N How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Marijuana or other drugs: \_\_\_\_\_ Y N Frequency: \_\_\_\_\_

Alcohol: \_\_\_\_\_ Y N Drinks per day/week? \_\_\_\_\_

History of alcohol addiction: \_\_\_\_\_ Y N

History of eating disorder: \_\_\_\_\_ Y N

Are you allergic to any medications? If so which one(s) and what is your reaction?

\_\_\_\_\_

Present weight: \_\_\_\_\_ Height: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_

Maximum weight & when: \_\_\_\_\_ Minimum weight as an adult & when: \_\_\_\_\_

Ideal weight: \_\_\_\_\_

How often do you exercise? \_\_\_\_\_ For how long? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ What time do you go to sleep? \_\_\_\_\_

Quality of sleep? \_\_\_\_\_

Nightmares: Y N Wake refreshed: Y N Must Nap During the Day: Y N

Sleep walk: Y N Grind teeth: Y N Snore: Y N

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? \_\_\_\_\_

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline, or other vapors? \_\_\_\_\_

Do you use pesticides, herbicides or other chemicals around your home? \_\_\_\_\_

Social History

Enjoy work: Y N Hours worked per week: \_\_\_\_\_ Active spiritual practices: Y N

Quality of significant relationship: \_\_\_\_\_

Stress Level: \_\_\_\_\_

What activities do you enjoy doing: \_\_\_\_\_

How committed are you towards making changes in your health:



**SYSTEMS SURVEY FORM**  
(Restricted to Professional Use)

PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

**INSTRUCTIONS:** Circle the number that applies to you. If a symptom does not apply, leave it blank.  
Circle either: (1) for **MILD** symptoms (occurs rarely), (2) for **MODERATE** symptoms (occurs several times a month),  
or (3) for **SEVERE** symptoms (occurs almost constantly).

**GROUP ONE**

- |                                   |  |                                   |
|-----------------------------------|--|-----------------------------------|
| 1 - 1 2 3 Acid foods upset        | 8 - 1 2 3 Gag Easily                       | 15 - 1 2 3 Appetite reduced       |
| 2 - 1 2 3 Get chilled, often      | 9 - 1 2 3 Unable to relax, startles easily | 16 - 1 2 3 Cold sweats often      |
| 3 - 1 2 3 "Lump" in throat        | 10 - 1 2 3 Extremities cold, clammy        | 17 - 1 2 3 Fever easily raised    |
| 4 - 1 2 3 Dry mouth-eyes-nose     | 11 - 1 2 3 Strong light irritates          | 18 - 1 2 3 Neuralgia-like pains   |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced            | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up - fail to calm | 13 - 1 2 3 Heart pounds after retiring     | 20 - 1 2 3 Sour stomach frequent  |
| 7 - 1 2 3 Cuts heal slowly        | 14 - 1 2 3 "Nervous" stomach               |                                   |

**GROUP TWO**

- |   |  |  |
|---|--|--|
| 21 - 1 2 3 Joint stiffness after arising                    | 29 - 1 2 3 Digestion rapid                       | 37 - 1 2 3 "Slow starter"                          |
| 22 - 1 2 3 Muscle-leg-toe cramps at night                   | 30 - 1 2 3 Vomiting frequent                     | 38 - 1 2 3 Get "chilled" infrequently              |
| 23 - 1 2 3 "Butterfly" stomach, cramps                      | 31 - 1 2 3 Hoarseness frequent                   | 39 - 1 2 3 Perspire easily                         |
| 24 - 1 2 3 Eyes or nose watery                              | 32 - 1 2 3 Breathing irregular                   | 40 - 1 2 3 Circulation poor,<br>sensitive to cold  |
| 25 - 1 2 3 Eyes blink often                                 | 33 - 1 2 3 Pulse slow; feels "irregular"         | 41 - 1 2 3 Subject to colds,<br>asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy                           | 34 - 1 2 3 Gagging reflex slow                   |  |
| 27 - 1 2 3 Indigestion soon after meals                     | 35 - 1 2 3 Difficulty swallowing                 |  |
| 28 - 1 2 3 Always seem hungry;<br>feels "lightheaded" often | 36 - 1 2 3 Constipation,<br>diarrhea alternating |  |

**GROUP THREE**

- |   |  |   |
|---|--|---|
| 42 - 1 2 3 Eat when nervous               | 49 - 1 2 3 Heart palpitates if meals<br>missed or delayed              | 53 - 1 2 3 Crave candy or coffee<br>in afternoons         |
| 43 - 1 2 3 Excessive appetite             | 50 - 1 2 3 Afternoon headaches   | 54 - 1 2 3 Moods of depression -<br>"blues" or melancholy |
| 44 - 1 2 3 Hungry between meals           | 51 - 1 2 3 Overeating sweets upsets                                    | 55 - 1 2 3 Abnormal craving for<br>sweets or snacks       |
| 45 - 1 2 3 Irritable before meals         | 52 - 1 2 3 Awaken after few hours sleep<br>- hard to get back to sleep |   |
| 46 - 1 2 3 Get "shaky" if hungry          |  |   |
| 47 - 1 2 3 Fatigue, eating relieves       |  |   |
| 48 - 1 2 3 "Lightheaded" if meals delayed |  |   |

**GROUP FOUR**

- |   |   |  |
|---|---|--|
| 56 - 1 2 3 Hands and feet go to sleep<br>easily, numbness | 63 - 1 2 3 Get "drowsy" often   | 68 - 1 2 3 Bruise easily, "black<br>and blue" spots  |
| 57 - 1 2 3 Sigh frequently, "air<br>hunger"               | 64 - 1 2 3 Swollen ankles<br>worse at night                                       | 69 - 1 2 3 Tendency to anemia  |
| 58 - 1 2 3 Aware of "breathing<br>heavily"                | 65 - 1 2 3 Muscle cramps, worse<br>during exercise; get<br>"charley horses"       | 70 - 1 2 3 "Nose bleeds" frequent  |
| 59 - 1 2 3 High altitude discomfort                       | 66 - 1 2 3 Shortness of breath<br>on exertion                                     | 71 - 1 2 3 Noises in head, or<br>"ringing in ears"   |
| 60 - 1 2 3 Opens windows in<br>closed room                | 67 - 1 2 3 Dull pain in chest or<br>radiating into left arm,<br>worse on exertion | 72 - 1 2 3 Tension under the<br>breastbone, or feeling<br>of "tightness",<br>worse on exertion |
| 61 - 1 2 3 Susceptible to colds<br>and fevers             |   |  |
| 62 - 1 2 3 Afternoon "yawner"                             |   |  |

**GROUP FIVE**

- |   |  |   |
|---|--|---|
| <b>73</b> - 1 2 3 Dizziness                                   | <b>83</b> - 1 2 3 Feeling queasy; headache over eyes           | <b>91</b> - 1 2 3 Sneezing attacks                    |
| <b>74</b> - 1 2 3 Dry skin                                    | <b>84</b> - 1 2 3 Greasy foods upset                           | <b>92</b> - 1 2 3 Dreaming, nightmare type bad dreams |
| <b>75</b> - 1 2 3 Burning feet                                | <b>85</b> - 1 2 3 Stools light-colored                         | <b>93</b> - 1 2 3 Bad breath (halitosis)              |
| <b>76</b> - 1 2 3 Blurred vision                              | <b>86</b> - 1 2 3 Skin peels on foot soles                     | <b>94</b> - 1 2 3 Milk products cause distress        |
| <b>77</b> - 1 2 3 Itching skin and feet                       | <b>87</b> - 1 2 3 Pain between shoulder blades                 | <b>95</b> - 1 2 3 Sensitive to hot weather            |
| <b>78</b> - 1 2 3 Excessive falling hair                      | <b>88</b> - 1 2 3 Use laxatives                                | <b>96</b> - 1 2 3 Burning or itching anus             |
| <b>79</b> - 1 2 3 Frequent skin rashes                        | <b>89</b> - 1 2 3 Stools alternate from soft to watery         | <b>97</b> - 1 2 3 Crave sweets                        |
| <b>80</b> - 1 2 3 Bitter, metallic taste in mouth in mornings | <b>90</b> - 1 2 3 History of gallbladder attacks or gallstones |   |
| <b>81</b> - 1 2 3 Bowel movements painful or difficult        |  |   |
| <b>82</b> - 1 2 3 Worrier, feels insecure                     |  |   |

**GROUP SIX**

- |  |  |  |
|--|--|--|
| <b>98</b> - 1 2 3 Loss of taste for meat                       | <b>101</b> - 1 2 3 Coated tongue                           | <b>104</b> - 1 2 3 Mucous colitis or "irritable bowel"                     |
| <b>99</b> - 1 2 3 Lower bowel gas several hours after eating   | <b>102</b> - 1 2 3 Pass large amounts of foul-smelling gas | <b>105</b> - 1 2 3 Gas shortly after eating                                |
| <b>100</b> - 1 2 3 Burning stomach sensations, eating relieves | <b>103</b> - 1 2 3 Indigestion 1/2 - 1 hour after          | <b>106</b> - 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after |

**GROUP SEVEN**

- |   |   |   |
|---|---|---|
| (A)   |   | (E)   |
| <b>107</b> - 1 2 3 Insomnia                                   |   | <b>150</b> - 1 2 3 Dizziness                            |
| <b>108</b> - 1 2 3 Nervousness                                |   | <b>151</b> - 1 2 3 Headaches                            |
| <b>109</b> - 1 2 3 Can't gain weight                          | (C)   | <b>152</b> - 1 2 3 Hot flashes                          |
| <b>110</b> - 1 2 3 Intolerance to heat                        | <b>137</b> - 1 2 3 Failing memory                           | <b>153</b> - 1 2 3 Increased blood pressure             |
| <b>111</b> - 1 2 3 Highly emotional                           | <b>138</b> - 1 2 3 Low blood pressure                       | <b>154</b> - 1 2 3 Hair growth on face or body (female) |
| <b>112</b> - 1 2 3 Flush easily                               | <b>139</b> - 1 2 3 Increased sex drive                      | <b>155</b> - 1 2 3 Sugar in urine (not diabetes)        |
| <b>113</b> - 1 2 3 Night sweats                               | <b>140</b> - 1 2 3 Headaches, "splitting or rendering" type | <b>156</b> - 1 2 3 Masculine tendencies (female)        |
| <b>114</b> - 1 2 3 Thin, moist skin                           | <b>141</b> - 1 2 3 Decreased sugar tolerance                | (F)   |
| <b>115</b> - 1 2 3 Inward trembling                           | (D)   | <b>157</b> - 1 2 3 Weakness, dizziness                  |
| <b>116</b> - 1 2 3 Heart palpitates                           | <b>142</b> - 1 2 3 Abnormal thirst                          | <b>158</b> - 1 2 3 Chronic fatigue                      |
| <b>117</b> - 1 2 3 Increased appetite without weight gain     | <b>143</b> - 1 2 3 Bloating of abdomen                      | <b>159</b> - 1 2 3 Low blood pressure                   |
| <b>118</b> - 1 2 3 Pulse fast at rest                         | <b>144</b> - 1 2 3 Weight gain around hips or waist         | <b>160</b> - 1 2 3 Nails, weak, ridged                  |
| <b>119</b> - 1 2 3 Eyelids and face twitch                    | <b>145</b> - 1 2 3 Sex drive reduced or lacking             | <b>161</b> - 1 2 3 Tendency to hives                    |
| <b>120</b> - 1 2 3 Irritable and restless                     | <b>146</b> - 1 2 3 Tendency to ulcers, colitis              | <b>162</b> - 1 2 3 Arthritic tendencies                 |
| <b>121</b> - 1 2 3 Can't work under pressure                  | <b>147</b> - 1 2 3 Increased sugar tolerance                | <b>163</b> - 1 2 3 Perspiration increase                |
| (B)   | <b>148</b> - 1 2 3 Women: menstrual disorders               | <b>164</b> - 1 2 3 Bowel disorders                      |
| <b>122</b> - 1 2 3 Increase in weight                         | <b>149</b> - 1 2 3 Young girls: lack of menstrual function  | <b>165</b> - 1 2 3 Poor circulation                     |
| <b>123</b> - 1 2 3 Decrease in appetite                       |   | <b>166</b> - 1 2 3 Swollen ankles                       |
| <b>124</b> - 1 2 3 Fatigue easily                             |   | <b>167</b> - 1 2 3 Crave salt                           |
| <b>125</b> - 1 2 3 Ringing in ears                            |   | <b>168</b> - 1 2 3 Brown spots or bronzing of skin      |
| <b>126</b> - 1 2 3 Sleepy during day                          |   | <b>169</b> - 1 2 3 Allergies - tendency to asthma       |
| <b>127</b> - 1 2 3 Sensitive to cold                          |   | <b>170</b> - 1 2 3 Weakness after colds, influenza      |
| <b>128</b> - 1 2 3 Dry or scaly skin                          |   | <b>171</b> - 1 2 3 Exhaustion - muscular and nervous    |
| <b>129</b> - 1 2 3 Constipation                               |   | <b>172</b> - 1 2 3 Respiratory disorders                |
| <b>130</b> - 1 2 3 Mental sluggishness                        |   |   |
| <b>131</b> - 1 2 3 Hair coarse, falls out                     |   |   |
| <b>132</b> - 1 2 3 Headaches upon arising wear off during day |   |   |
| <b>133</b> - 1 2 3 Slow pulse, below 65                       |   |   |
| <b>134</b> - 1 2 3 Frequency of urination                     |   |   |
| <b>135</b> - 1 2 3 Impaired hearing                           |   |   |
| <b>136</b> - 1 2 3 Reduced initiative                         |   |   |

