Richart Chiropractic and Functional Medicine
Dr. Robert Richart, D.C., CFMP, FIAMA
Chiropractic Physician
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<u>Please note</u>: We require your completed paperwork at least 3 days prior to your consultation so Dr. Richart can review it prior to the appointment. Please email your completed paperwork to drrichart@hotmail.com or fax to 847-657-8661. Thank you!

FUNCTIONAL MEDICINE NEW PATIENT FORM

Name:				Date:
Address:				Country:
City:		State:		Zip/Postal Code:
Home Phone:	Work Phone:			Cell Phone:
E-mail:				Sex: _____ M _____ F
Please mark your preference for occasional follow up communication from our office: _____Email_____Phone				
Age:	Birth Date:	Status:	_____ M ____ S ___ W ____D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Years Married:
Referred by:		Current M.D.		
What are your major complaints?				
Any other complaints?				
How long has it been since you really felt good?				

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Dr. Robert Richart to release my personal medical information to me.

Patient's Signature: _____ Date: _____

Patient's Name: _____ Date: _____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

1. Height Weight Blood Pressure (if known)

2. Are you presently taking any medications, nutritional supplements or vitamins? Yes or No
please list (attach sheet if necessary)

_____

3. If you have fillings, please list material(s) used: _____

4. Do you have any food allergies, sensitivities or restrictions? _____

5. What are your main sources of stress? _____

_____

6. How do you deal with your stress? _____

_____

7. Check off any of the following that have applied to you in the last year:

_____Do you feel nauseous?

_____Do you have abdominal/intestinal pain?

_____Do you have bloating?

_____Do you get bloated after meals?

_____Do you get heartburn?

_____Do you have diarrhea?

_____Do you have constipation?

_____Do you travel outside of the U.S.?

_____Do you have gas?

_____Are your stools compact/hard to pass?

8. Surgeries or hospitalizations: _____

_____

9. Briefly describe where you have lived since childhood: _____

_____

_____

10. What is your heritage? (Irish, German, Spanish, etc.) _____

_____