FoxCare Integrative Health
www.foxcareintegrativehealth.com
Tel: 434.290.1210 | Fax: 434.282.2552

Please take the time to fill these forms out completely so we can best help you. We realize that not all for the questions may pertain to you, but please answer all that apply. Thank you.

Patient Full Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____ Weight _____

Primary Care Doctor: _____

Other Physicians in your care team: _____

Reason(s) for Visit: _____

Preferred Pharmacy and Address: _____

Are you able to swallow Pills? ☐Yes ☐No

Allergies ☐No Allergies to medications

(List all medications, foods, and environmental)

Name	Reaction that Occurs

Current Health Concerns

(Please rank current and ongoing health concerns in order of priority)

Describe Problem	Severity (Mild, Moderate, Severe)	Prior Treatment/Approach	Success (Excellent, Good, Fair)
Example: Post Nasal Drip	Mild	Elimination Diet	Excellent
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

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Medication Overview

Prescription Medications ☐**No Medications**

(Please include Rx and over the counter medications)

Date Started	Medications & Dose	Directions	Reason for Taking	Prescribed By

Supplements ☐**No Supplements**

Date Started	Supplement & Dose	Directions	Reason for Taking	Prescribed By

Have medications or supplements ever caused unusual side effects or problems? ☐Yes ☐No

If yes, describe: _____

Have you ever used any of these regularly or for a long time?

NSAIDS (Advil, Aleve, etc.), Motrin Aspirin: ☐Yes ☐No

Acid-blocking drugs (Zantac, Pepcid, Prilosec, Nexium, etc.): ☐Yes ☐No

How many times have you taken antibiotics? _____

Have you ever taken long term antibiotics? ☐Yes ☐No If yes, explain: _____

_____

How often have you taken oral steroids (e.g. cortisone, prednisone, etc.)? _____ And was it beneficial? ☐Yes ☐No

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Medical History

Past Medical History
(Please check all that apply and give specifics where needed)

☐ **Digestive Issues (e.g. reflux, celiac, IBS, Eating disorder) Please specify:**	☐ **Thyroid: Please specify hyperthyroidism or hypothyroidism**
☐ **Constipation**	☐ **ADHD Specify type:**
☐ **Multiple Chemical Sensitivities**	☐ **PANS/PANDAS: Symptoms Onset _____**
☐ **Chronic Fatigue Syndrome ☐ Chronic Pain**	☐ **Lyme Disease/Co-infections: Symptoms Onset_____**
☐ **Immune Deficiency**	☐ **Autism: Diagnosis date_____**
☐ **POTS: Symptoms Onset _____**	☐ **Eczema**

Please list any other past medical history: _____

_____

Have you negatively reacted to vaccines? ☐Yes ☐No If yes, what vaccine, when, and describe reaction: _____

_____

Have you had the Covid Vaccine? ☐Yes ☐No If yes, which type: _____

Past Hospitalizations? ☐Yes ☐No If yes, please give date and reason: _____

_____

Past Surgeries? ☐Yes ☐No If yes, please give date and reason: _____

_____

Lifestyle Review

How many hours of sleep do you get each night on average? _____ Do you limit screen time in the hour before bed? ☐Yes ☐No

On a typical night: What time is lights out? _____ Wake up time? _____

Do you mostly keep the same lights out, wake up schedule 7 days a week? ☐Yes ☐No

Do you have a problem falling asleep? ☐Yes ☐No Problem staying asleep? ☐Yes ☐No

Do you snore? ☐Yes ☐No Are you an active sleeper? (kicking or turning in sleep) ☐Yes ☐No

Do you feel rested upon awakening? ☐Yes ☐No

Do you use sleeping aids of medications? ☐Yes ☐No If yes, explain: _____

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Personal Habits

How often do you bathe? _____ Do you use an IR Sauna? ☐Yes ☐No Frequency _____

Do you have a daily bowel movement? ☐Yes ☐No If not, how often _____?

What is the consistency of most stools? ☐Firm/Hard ☐Soft ☐Liquid

Hydration: ☐Good Hydration ☐Moderate Hydration ☐Poor Hydration

Do you have good urine output? ☐Yes ☐No Is your urine pale? ☐Yes ☐No

Physical Activity

Current Exercise/Activities and the Duration (General Activities or Formal Teams): _____

_____

_____

Do you feel motivated to exercise? ☐Yes ☐No

Are there any problems that limit exercise? ☐Yes ☐No If yes, explain _____

_____

Do you feel unusually fatigued or sore after exercise? ☐Yes ☐No If yes, explain _____

_____

Diet and Nutrition

Do you currently follow an of the following special diets or nutritional programs: (Check all that apply)

☐ Vegetarian	☐Vegan	☐Pescatarian	☐High Protein
☐Auto-Immune Paleo	☐No Dairy	☐No Wheat	☐Gluten Free
☐Dairy Free	☐Elimination	☐Standard American Diet	☐Other _____

Do you eat a well-balanced diet? ☐Yes ☐No If no, explain: _____

How many meals do you eat per day? _____

Do you more often, ☐ eat out or ☐ cook at home?

Do you drink caffeinated beverages? ☐Yes ☐No If yes, what kind and how many cups per day? _____

Do you have adverse reactions to caffeine? ☐Yes ☐No If yes, explain _____

Do you have sensitivities to certain foods? ☐Yes ☐No If yes, list foods and symptoms: _____

_____

Do you have an aversion to certain foods? ☐Yes ☐No If yes, explain: _____

_____

Are there any foods that you crave or binge on? ☐Yes ☐No If yes, which foods? _____

_____

If you are a picky eater, please list food that you will eat: _____

_____

Stress

Do you feel you have an excessive amount of stress in your life? ☐Yes ☐No

Do you feel that you can easily handle the stress in your life? ☐Yes ☐No

Which of the following are stressors:

☐Work/School ☐Family ☐Social ☐Finances ☐Health ☐Other_____

Do you use mindfulness techniques? ☐Yes ☐No If yes, how often? _____

What techniques to you use:

☐Meditation ☐Breathing ☐Tai Chi ☐Yoga ☐Prayer ☐Other_____

Have you ever sought counseling? ☐Yes ☐No

Are you currently in therapy? ☐Yes ☐No If yes, describe _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐Yes ☐No

Trauma history: Have you ever directly experienced or witnessed trauma? ☐Yes ☐No If yes, when and what? _____

_____

Relationships

With whom do you life? (Include children, parents, siblings, relations, friends, pets) _____

_____

Do you have a religious or spiritual practice? ☐Yes ☐No If yes, what kind? _____

How well have things been going for you?

Mark on scale 1-10, or N/A if not applicable

	N/A	Poorly				Fine					Very Well
Overall	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10

In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With you siblings	☐	1	2	3	4	5	6	7	8	9	10
With your partner	☐	1	2	3	4	5	6	7	8	9	10

Patients' Birth/Childhood History

You were born: ☐Full Term ☐Premature, How many weeks _____ ☐Don't Know

You were born: ☐Vaginal ☐C-section, due to _____ Pregnancy number _____

Any complications with pregnancy? ☐Yes ☐No If yes, explain _____

Any complications with delivery? ☐Yes ☐No If yes, explain _____

You were: ☐Breastfeed, how long? _____ ☐Bottle-fed, type of formula: _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐Yes ☐No

If yes, what foods and what symptoms? (Example: milk – gas and diarrhea): _____

_____

Dental History

Do you brush regularly? ☐Yes ☐No How many times per day? _____

Do you floss regularly? ☐Yes ☐No How many times per week? _____

How many fillings (estimate) _____ and what kinds _____?

Menstrual History: (Females Only) ☐Not Applicable

Have you had your first period? ☐Yes ☐No If yes, what age did it start _____

Date of last menstrual period _____ Length of cycle _____

What are your typical PMS symptoms? _____

Does your medical condition seem to worsen around your period? ☐Yes ☐No If you, explain _____

_____

Do you use birth control? ☐Yes ☐No If yes, explain type _____

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Environmental/Detoxification History

Question	Yes	No
Have you lived in a mobile home, boat, or very old or brand-new home? If so, please describe:		
Does your home or school have visible mold, water damage, damp windows, or basement/crawlspaces? Or has been remediated of mold at any point?		
Do you regularly use conversation cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or school and noticed worsening symptoms?		
Do you smoke or are often exposed to secondhand smoke?		
Are you highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?		
Have you had any unusual reactions to anesthesia or to prescription or over-the-counter medications? If so, please describe:		
Do you have any pets or farm animals? If yes, are they inside or outside?		
Any other known environmental exposures to heavy metals or pesticides?		

Family History

	Mother	Father	Brother(s)	Sister(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)									
Age at death (if deceased)									
Autoimmune Diseases									
Thyroid Problems									
Psychiatric disorders Schizophrenia / Bipolar Other _____									
Anxiety									
Depression									
Arrhythmia Long QT Syndrome Other _____									

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Readiness Assessment and Health Goals

Rate on a scale of 5 (very willing) to 1 (not willing
To improve your health how willing are you to:

Significantly modify your diet	☐5	☐4	☐3	☐2	☐1
Take several nutritional supplements each day	☐5	☐4	☐3	☐2	☐1
Modify your lifestyle (e.g., 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

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities?	☐5	☐4	☐3	☐2	☐1
At the present time, how supportive do you think the people in your household will be to implementing the above changes?	☐5	☐4	☐3	☐2	☐1

If you are not confident of your ability to improve your health goals, what aspects of yourself or your life lead you to question your capacity to follow through? _____

_____

If pediatric patient, are both parents involved in and committed to helping the child on this health journey? ☐Yes ☐No

If no, please explain _____

_____

What do you hope to achieve in your visit with us? _____

_____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel better and worse? _____

_____

What do you think is happening and why? _____

_____

What do you feel needs to happen for you to get better? _____

_____

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Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months:

General	Mild	Moderate	Severe
Cold Intolerance	☐	☐	☐
Heat Intolerance	☐	☐	☐
Daytime Sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Difficulty staying asleep	☐	☐	☐
Nightmares	☐	☐	☐
Chronic Fatigue	☐	☐	☐
Head, Eyes, & Ears	**Mild**	**Moderate**	**Severe**
Headaches	☐	☐	☐
Migraine	☐	☐	☐
Blurry Vision	☐	☐	☐
Musculoskeletal	**Mild**	**Moderate**	**Severe**
Joint Pain What joint _____	☐	☐	☐
Joint Redness What joint _____	☐	☐	☐
Joint Stiffness What joint _____	☐	☐	☐
Muscle Pain What muscle _____	☐	☐	☐
Muscle Twitches What muscle _____	☐	☐	☐
Motor Tics	☐	☐	☐
Vocal Tics	☐	☐	☐
Mood/Nerves	**Mild**	**Moderate**	**Severe**
Anxiety	☐	☐	☐
Social Anxiety	☐	☐	☐
Separation Anxiety	☐	☐	☐
Depression	☐	☐	☐
Dizziness / Lightheadedness	☐	☐	☐
Emotional lability	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irrational Fears**	☐	☐	☐
Panic attacks	☐	☐	☐
Hallucinations	☐	☐	☐
Auditory **	☐	☐	☐
Visual**	☐	☐	☐
Irritability	☐	☐	☐
Other phobias	☐	☐	☐
Suicidal thoughts	☐	☐	☐

Mood/Nerves Cont.	Mild	Moderate	Severe
Tremors/trembling	☐	☐	☐
Cardiovascular	**Mild**	**Moderate**	**Severe**
Breathlessness	☐	☐	☐
Heart Murmur	☐	☐	☐
Irregular Pulse	☐	☐	☐
Palpitations	☐	☐	☐
Specific Cardiac Condition _____	☐	☐	☐
Skin Problems	**Mild**	**Moderate**	**Severe**
Eczema	☐	☐	☐
Hives	☐	☐	☐
Itching Skin Where? _____	☐	☐	☐
Urinary	**Mild**	**Moderate**	**Severe**
Bed Wetting How often _____	☐	☐	☐
Accidents	☐	☐	☐
Leaking/Incontinence	☐	☐	☐
Urgency	☐	☐	☐
Digestion	**Mild**	**Moderate**	**Severe**
Bloating How often?_____	☐	☐	☐
Lower Abdomen	☐	☐	☐
Whole Abdomen	☐	☐	☐
After meals	☐	☐	☐
Pain	☐	☐	☐
Lower Abdomen	☐	☐	☐
Whole Abdomen	☐	☐	☐
After meals	☐	☐	☐
Excessive Burping	☐	☐	☐
Excessive Gas	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty Foods	☐	☐	☐
Soy	☐	☐	☐
Yeast	☐	☐	☐
Other _____	☐	☐	☐

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Digestion Cont.	**Mild**	**Moderate**	**Severe**
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Blood in stools	☐	☐	☐
Difficulty Swallowing	☐	☐	☐
Heartburn	☐	☐	☐
Mucus in Stool	☐	☐	☐
Vomiting	☐	☐	☐
Regular Nausea	☐	☐	☐
Eating	**Mild**	**Moderate**	**Severe**
Binge Eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't Gain Weight	☐	☐	☐
Can't Lose Weight	☐	☐	☐
Carbohydrate Craving	☐	☐	☐
Salt Craving	☐	☐	☐
Sweet Cravings	☐	☐	☐
Poor Appetite	☐	☐	☐
Picky Eater	☐	☐	☐
Frequent Dieting	☐	☐	☐
Unexplained weight loss	☐	☐	☐
Unexplained weight gain	☐	☐	☐
Respiratory	**Mild**	**Moderate**	**Severe**
Hoarseness	☐	☐	☐
Nasal Stuffiness Seasonal? _____	☐	☐	☐
Nose Bleeds	☐	☐	☐
Postnasal Drip	☐	☐	☐
Sinus infections	☐	☐	☐
Snoring	☐	☐	☐
Wheezing	☐	☐	☐

**List any irrational fears: _____

_____

**Describe any auditory hallucinations: _____

_____

**Describe any visual hallucinations: _____

_____