THE HEALING COLLECTIVE
FUNCTIONAL MEDICINE

The Healing Collective
6800 N 79th St, Suite 202
Niwot, Colorado, US - 80503

ACU: Initial Appt Intake Form

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

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Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

*Do we have permission to leave details on this phone's voicemail regarding your treatment? Y / N

☐ Yes ☐ No

Initial:

How did you hear about The Healing Collective? *

☐ Referral from provider at Holos Health
☐ Referral from another provider (please share their name below)
☐ Through family/friend (please share their name below)
☐ Search engine (google, bing, etc.)
☐ Facebook
☐ Instagram
☐ Yelp
☐ Institute for Functional Medicine website
☐ Frequency Specific Microcurrent website

If applicable, please share more about how you heard about The Healing Collective

Top Three Goals for Today's Appointment: (ex: 1. Improve knee pain 2. Support liver 3. Strategies for low back pain)

If you could feel any way walking out of your appointment, would would that be? *

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Main Priority for Your Overall Health:

I Believe That I can Feel 100% Better. ☐ Yes ☐ No

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Current Medical Providers & type of care
For example: PCP = Dr. Shaw
Acupuncturist = Lynn Lewis

If you would like Jennifer to be in contact with your primary care provider (sending an Initial Evaluation, Progress Notes, and a Discharge Note), please include their full name, practice name, phone number and practice address below:

Allergies

Allergies	Type	Severity	Reactions

Hospitalizations and/or surgeries:
Diagnosis, Procedure, Approximate Date

Lifestyle/Social

Current Exercise: Frequency, Intensity, Duration

Diet: Current and past diets, food intolerances, avoidances

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Relationship Status: Married, Single, Divorced, In Relationship, Children, etc. _____

Feel safe at home? ☐ Yes ☐ No

Living Situation details _____

Drug Use _____

Alcohol _____

Smoking _____

List the LOCATION, DATE & RESULTS screenings below, if applicable. Answer as best you can—if exact date is unknown, list your best guess.
*****If there is imaging related to this episode of care, please bring it with you to your appointment or call our front desk to coordinate a records request so Jennifer can see your imaging at the first visit.*****

Bone Mineral Density Screening/DEXA Scan: List date, location and results

MRI: List date, location and results

CAT Scan / CT Scan: List date, location and results

X-Ray / Radiograph: List date, location and results

Ultrasound: List date, location and results

Mammogram List date, location and results

Colonoscopy: List date, location and results

Current or Past Health Conditions
(Check box and add additional details as pertinent)

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Musculoskeletal *

- [ ] None
- [ ] Weakness
- [ ] Numbness
- [ ] Tingling
- [ ] Tendinitis
- [ ] Bursitis
- [ ] Arthritis
- [ ] Rheumatoid Arthritis
- [ ] Gout
- [ ] Strain
- [ ] Sprain
- [ ] Fracture
- [ ] Low back pain
- [ ] Leg pain
- [ ] Hip pain
- [ ] Neck pain
- [ ] Headache
- [ ] Migraine
- [ ] Shoulder pain
- [ ] Arm pain
- [ ] Burner or Stinger
- [ ] Jaw pain
- [ ] TMJ disorder
- [ ] Ehlers Danlos Syndrome (EDS)
- [ ] Scoliosis

Nervous System *

- [ ] None
- [ ] Alzheimer's
- [ ] Bell's Palsy
- [ ] History of ANY Concussion
- [ ] C-section birth
- [ ] Cytomegalovirus
- [ ] Dementia
- [ ] Dizziness
- [ ] Epstein-Barr Virus
- [ ] Epilepsy
- [ ] Fainting
- [ ] Guillain-Barre
- [ ] Headaches
- [ ] Lyme or Co-Infections
- [ ] Migraines
- [ ] Mold Exposure
- [ ] Mono
- [ ] Multiple Sclerosis
- [ ] Numbness / Tingling
- [ ] Parkinson's
- [ ] Pinched nerve
- [ ] Polio
- [ ] Seizures
- [ ] Shingles
- [ ] Speech / Swallowing Problems
- [ ] STDs
- [ ] Tinnitus
- [ ] Traumatic brain injury
- [ ] Trigeminal Neuralgia
- [ ] Typhoid
- [ ] Tuberculosis

Trauma *

- [ ] None
- [ ] PTSD
- [ ] Motor Vehicle Accident (even if minor)
- [ ] Fall from Height
- [ ] Closed Head Injury
- [ ] Concussion
- [ ] Traumatic brain injury
- [ ] mTBI
- [ ] Surgery
- [ ] Spinal Tap
- [ ] Spinal Puncture
- [ ] Injection into spine
- [ ] Epidural
- [ ] Spine surgery
- [ ] Physical Abuse
- [ ] Sexual Abuse
- [ ] Emotional Abuse
- [ ] Early Childhood Trauma
- [ ] Traumatic Experiences or Events Not Listed

Cardiac *

- [ ] None
- [ ] Chest Pain
- [ ] Palpitations
- [ ] Arrhythmia
- [ ] Exercise Intolerance
- [ ] Heart Attack
- [ ] Stroke / Brain Attack
- [ ] Phlebitis / Varicose Veins
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Lymphedema
- [ ] Embolism
- [ ] Pacemaker
- [ ] Anemia

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Psychiatric/Mental Health *
- [ ] None
- [ ] Depression
- [ ] Anxiety
- [ ] Mood Disorder
- [ ] Personality Disorder
- [ ] Schizophrenia
- [ ] PTSD
- [ ] Disordered Eating
- [ ] Addiction
- [ ] Insomnia

Respiratory *
- [ ] None
- [ ] Sinus Problems
- [ ] Chronic Cough
- [ ] Asthma
- [ ] Exercise-induced Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Shortness of Breath
- [ ] Difficulty Breathing
- [ ] Tuberculosis

Dermatology *
- [ ] None
- [ ] Rash
- [ ] Itching
- [ ] Athlete's foot
- [ ] Herpes / Cold Sore
- [ ] Skin Cancer
- [ ] Eczema
- [ ] Psoriasis

Endocrine *
- [ ] Hypothyroid
- [ ] Hyperthyroid
- [ ] Hashimoto's
- [ ] Grave's Disease
- [ ] Pituitary dysfunction
- [ ] Pancreatitis
- [ ] Pancreas dysfunction
- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes
- [ ] Osteoporosis
- [ ] Osteopenia
- [ ] Addison's
- [ ] Cushing's

Ears, Eyes, Nose, Throat *
- [ ] None
- [ ] Ear Pain
- [ ] Hearing loss
- [ ] Tinnitus / Ringing in Ears
- [ ] Vision Change
- [ ] Congestion
- [ ] Sinusitis
- [ ] Sore Throat
- [ ] Frequent Infections
- [ ] Eye pain
- [ ] Visual disturbances
- [ ] Double vision

Gastrointestinal *
- [ ] None
- [ ] Pain
- [ ] Gas
- [ ] Bloating
- [ ] Diarrhea
- [ ] Constipation
- [ ] IBS
- [ ] Infections
- [ ] Reflux
- [ ] Ulcers
- [ ] Colitis
- [ ] SIBO
- [ ] Low back pain
- [ ] Pelvic pain

Female Health *
- [ ] None
- [ ] Infertility
- [ ] Pregnancy Loss
- [ ] Fibroid
- [ ] Ovarian Cyst
- [ ] PMS/PMDD
- [ ] Breast Concern
- [ ] Cancer
- [ ] STD
- [ ] Endometriosis
- [ ] Heavy menstruation
- [ ] Pelvic pain

Autoimmune Conditions: *
- [ ] None
- [ ] Hashimotos
- [ ] Grave's Disease
- [ ] Rheumatoid Arthritis
- [ ] Crohn's Disease
- [ ] Ulcerative Colitis
- [ ] Lupus

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Miscellaneous *

- ☐ None
- ☐ EVER had a kidney stone?
- ☐ Problems with barometric changes (flying, driving to mountains)
- ☐ Fibromyalgia
- ☐ Metal implant
- ☐ Sensitivity to anesthesia
- ☐ Cancer / Tumors
- ☐ Family history of kidney stones?
- ☐ Vestibular injury
- ☐ Contact lenses
- ☐ Chronic Fatigue
- ☐ Gall Bladder
- ☐ Saddle anesthesia
- ☐ Kidney or Bladder ailment
- ☐ Oxalate sensitivity
- ☐ Incontinence
- ☐ Any type of whiplash
- ☐ Chronic Pain
- ☐ Dizzy spells
- ☐ Sleep disorders
- ☐ Blacked out / loss of consciousness

Toxin Exposure:

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Toxin Exposure Screening - check if you have EVER encountered the following *

- ☐ None
- ☐ Grew up on/near farm
- ☐ Grew up near mine
- ☐ Exposure to poor water sanitation
- ☐ Workplace chemical exposure
- ☐ Lived in polluted area
- ☐ Lived in house with mold
- ☐ Eating non-organic foods
- ☐ Eating conventionally-raised meat products
- ☐ Consume seafood more than 2x/week
- ☐ Eat canned, fast foods with artificial colors, flavors
- ☐ Lived in mobile home, boat, RV
- ☐ Recent exposure to new construction materials (laminate, paint, flooring, particle board, ner carpet, new bedding, new furniture)
- ☐ Water damage at the workplace or home
- ☐ Adhesives, paints, flea treatments, varnishes, solvents, welding material, air-borne chemicals at home or work
- ☐ Drink water from a well, cistern, pipes installed before 1986
- ☐ Treated lumber, lead paint, paint chips, construction dust
- ☐ Broken mercury thermometer
- ☐ Handle or in close proximity to broken fluorescent bulbs
- ☐ Regularly use conventional cleaning chemicals, disinfectants, hand sanitizers,
- ☐ air fresheners, scented candles, or other scented products at home or work
- ☐ Health concerns related to time spent living or working adjacent to a highway, factory,
- ☐ incinerator, gas station, power plant, or other industrial pollution source
- ☐ Exposed to herbicides, pesticides, fungicides
- ☐ at home, work, parks & golf courses, or roadsides
- ☐ Live near a cell phone tower, high-voltage power lines, or other known source of
- ☐ electromagnetic radiation
- ☐ Live/work in sealed building with recirculated air or a building with wood,
- ☐ propane, or gas stoves or appliances
- ☐ Smoke, second-hand smoke
- ☐ Bike/walk/run along busy roadways
- ☐ Highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes
- ☐ Root canals, tooth extractions, “silver” fillings, crowns, dental sealants, dentures,
- ☐ retainers, aligning trays, braces, mouth guards, dental implants
- ☐ Unusual reactions to anesthesia or to prescription or over-the-counter medications
- ☐ History of heavy use of alcohol or recreational or prescription drugs

Stress- Has there been a period of time of severe stress *

☐ Yes ☐ No

If yes, when, how long, cause?

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Anything else: _____

Any additional comment that you would like to add:

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head:

Headaches:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Faintness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Dizziness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Insomnia	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

Total: _____

Eyes

Watery or itchy eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Swollen, reddened or sticky eyelids	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Bags or dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Blurred or tunnel visioin	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

Total _____

Ears

Itchy ears	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Ear aches, ear infections	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Drainage from ear	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
Ringing in ears, hearing loss	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

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Total _____

Nose

Stuffy nose ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Sinus problems ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Hay fever ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Sneezing attacks ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Excessive mucus formation ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Total _____

Mouth/Throat

Chronic coughing ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Gagging, frequent need to clear throat ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Swollen or discolored tongue, gums, lips ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Canker sores ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Total

Skin

Acne ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Hives, rashes, dry skin ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Excessive sweating ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Total _____

Heart

Irregular or skipped heartbeat ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Rapid or pounding heartbeat ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Chest pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Total _____

Lungs

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Chest congestion	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Asthma, bronchitis	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Shortness of breath	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Difficulty breathing	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

Digestive Tract

Nausea, vomiting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Diarrhea	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Constipation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Bloated feeling	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Belching, passing gas	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Heartburn	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Intestinal/ stomach pain	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

Joint/Muscle

Pain or aches in joints	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Arthritis	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Stiffness/ limitation of movement	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Pain or arches in muscles	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Feeling of weakness or tiredness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

Weight

Binge eating/ drinking	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Craving certain foods	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

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Excessive weight	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Compulsive eating	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Water retention	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Underweight	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	

Energy/ Activity

Fatigue, sluggishness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Apathy, lethargy	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Hyperactivity	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Restlessness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	

Mind

Poor memory	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Confusion, poor comprehension nervousness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Poor concentration	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Poor physical coordination	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Difficulty in making decisions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Stuttering or stammering	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Slurred speech	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Learning disabilities	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	

Emotions

Mood swings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Anxiety, fear	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

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Anger, irritability, aggressivess	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Depression	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

Sex Hormones

Hot flashes	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Low libido	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Insomnia	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Poor muscle tone	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Vaginal irritation/ dryness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Vaginal bleeding	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Breast tenderness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Breast lump	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Poor Circulation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Brain fog	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Weight gain	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Weight loss	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Cold intolerance	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Hair loss	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Skin dryness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

Other

Frequent illness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Frequent or urgent urination	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Genital itch or discharge	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Total	_____

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Grand Total

Anything else you would like to report?

At the Healing Collective, we have a 24 hour cancellation policy. Our providers spend hours preparing and gathering medical records, lab orders, and previous prescriptions so that your visit progresses smoothly. Any no-shows, cancellations, and changes in reservations within 24 hours of your visit will be subject to a 50% charge. Exceptions may be made for emergencies on a case-by-case review. *

☐ I consent

Do you acknowledge and accept the 24 hour cancellation policy as described above? *

☐ Yes ☐ No