

ACACIA WHOLE HEALTH
(303) 504-0772
NEW CLIENT FORM

Name _____

Street _____ Apt. # _____

City _____ State _____ Zip _____

Phone: (H) _____ (W) _____ (Cell) _____

eMail _____ Birthdate _____

Age _____ Marital Status _____ Children (Y/N)? _____

Employer Name _____

Employer Address _____

Physician _____ Date of last physical _____

Emergency Contact _____ Phone # _____

Relationship _____

Referred by _____

Payment is **Due In Full** at the time of service. Acacia Whole Health **does not** bill Health Insurance Companies or write letters for Health Flex Plans.

INITIAL CONSULTATION*:

Dr. Stefanie Funk - \$225.00

ALL FOLLOW-UP VISITS*:

30 Minutes - \$75.00

45 Minutes - \$100.00

60 Minutes - \$140.00

OTHER SERVICES (Cost/Session):

Frequency Generator - \$48.00

Ion Cleanse - \$35.00

*Above rates do not include Generator Sessions, Ion Cleanse Sessions, or Supplements.

Cancellation Notice: I understand that Acacia Whole Health has a 24-hour Advance Cancellation Policy. Clients canceling with less than 24 hours notice will be charged the following cancellation fees:

90 minute appointment - \$100.00

60 minute appointment - \$65.00

30 minute appointment - \$45.00

Please sign that you have read, fully understand, and agree to the above terms.

Signature _____ Date _____

FAMILY MEDICAL HISTORY (This does not refer to you but your family)

CIRCLE ALL THAT APPLY

CANCER
DIABETES
HIGH/LOW BLOOD
PRESSURE HEART
TROUBLE
TB
ALLERGIES
OTHER _____

KIDNEY DISEASE
EPILEPSY
ASTHMA
LIVER DISEASE
ULCERS
SINUS PROBLEMS
LYME DISEASE

ARTHRITIS
ALCOHOLISM
SPINAL PROBLEMS
MENTAL DISORDERS
DRUG ADDICTIONS

IF DECEASED, AGE PARENTS DIED: MOTHER _____ FATHER _____

PERSONAL MEDICAL HISTORY (Your medical history)

MAJOR SURGERIES, ILLNESSES, DISEASES, ACCIDENTS

ALLERGIES (DRUGS, CHEMICALS, FOOD, ANIMALS, SEASONAL, ETC.)

MEDICATIONS (INCLUDE VITAMINS, HERBS, PRESCRIPTIONS, HOMEOPATHICS AND ALL OVER THE COUNTER PREPARATIONS)

MAJOR COMPLAINT(S)

DATE BEGAN _____ HAS IT GOTTEN: WORSE SAME BETTER

DESCRIBE HOW IT STARTED

HAVE YOU EVER HAD THIS CONDITION BEFORE? _____

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? _____

IF YES, WHEN? _____ BY WHOM? _____

WHAT WERE THE RESULTS? _____

WHAT MAKES IT BETTER? _____ WORSE? _____

RESPIRATORY

SHORT OF BREATH
DIFFICULT INHALE
SIGH A LOT
CHEST PAIN
DIFFICULT EXHALE
OTHER _____

DRY COUGH
ASTHMA
COUGH/PHLEGM
BRONCHITIS
TIGHTNESS IN CHEST

COUGH/BLOOD
HARD TO BREATHE
LYING DOWN
NORMAL

CARDIOVASCULAR

DIAGNOSED HEART
PROBLEMS
PALPITATIONS
CHEST PAIN
LOW BLOOD PRESSURE
BLEED EASILY
ANKLE SWELLING
HIGH BLOOD
PRESSURE
OTHER _____

VARICOSE VEINS
FACIAL SWELLING
SLOW HEART BEAT
MURMUR
BRUISE EASILY
IRREGULAR
HEARTBEAT
HAND SWELLING
HISTORY OF ANEMIA

PURPLE
PALMS/FINGERS
BROKEN BLOOD
VESSELS
NUMBNESS IN
EXTREMITIES
NORMAL

PAIN

LOW BACK
SHOULDER
MUSCLE WEAKNESS
SCIATICA
HANDS/WRIST
MUSCLE CRAMPS
UPPER BACK
OTHER _____

HIPS
MUSCLE
SPASM/TWITCH
MID BACK
KNEES
BOTHERED BY DAMP
WEATHER

NECK
SPINE
FOOT/ANKLE
NERVE PAIN
ARTHRITIS
FLANK AREA

HAIR

DRY OILY DANDRUFF FALLING OUT EARLY GREY NORMAL

NAILS

SOFT
BREAK EASILY
PALE
OTHER _____

GROW SLOWLY
SPOTTY
RIDGES/LINES

PURPLE
GROW FAST
NORMAL

EARS

POOR HEARING
RINGING (HIGH PITCH)
OTHER _____

DISCHARGES
EARACHES

RINGING (LOW PITCH)
NORMAL

NOSE

STUFFY NOSE
HAYFEVER
SNEEZE A LOT
MUCOUS
OTHER _____

BLEEDING
LOSS OF SMELL
TMJ
RHINITIS

BLOW A LOT
ENVIRONMENTAL
SENSITIVITY
NORMAL

EYES

WEAR
GLASSES/CONTACTS
EYELIDS SWOLLEN
CATARACTS
SPOTS/LINES IN VISION
INFLAMMATION
GLAUCOMA
PALE UNDER EYELIDS
OTHER_____

YELLOW SCLERA
BLINK OFTEN
POOR NIGHT VISION
FAILING VISION
TWITCHING
SENSITIVE TO LIGHT
HISTORY OF STIES
STRAIN

COLOR BLINDNESS
BLURRY VISION
TEAR EASILY
RED
DRY
ITCH
PAIN
NORMAL

MOUTH/THROAT

DRY
GUM PROBLEMS
HOARSENESS
FREQUENT COLDS
TMJ
SORE THROAT (OFTEN)
SORES IN MOUTH
OTHER_____

SORES ON TONGUE
DIFFICULT
SWALLOWING
THYROID PROBLEMS
HICCUPS
DRY/CRACKED LIPS
DROOLING

GRIND TEETH
SWOLLEN GLANDS
LUMP IN THROAT
TEETH PROBLEMS
NORMAL

SKIN

DRY
HIVES
CLAMMY
ULCERS
OILY
PIMPLES
OTHER_____

BRUISE EASILY
BODY ODOR
RASHES
MOLES
CUTS HEAL SLOWLY
ITCHING

WARTS
YELLOW SKIN
ECZEMA
BOILS
NORMAL

URINATION (3-4 TIMES A DAY IS NORMAL)

FREQUENT
BURNING
URGENCY
BLADDER INFECTIONS
NIGHTTIME
BLOOD
OTHER_____

INCONTINENCE
KIDNEY STONES
PROFUSE
PUS
STRONG SMELL
CLOUDY

SCANTY
PAINFUL
UNUSUAL COLOR
NORMAL

THIRST

LESS THAN NORMAL
PREFER COLD DRINKS
EXCESSIVE
OTHER_____

THIRSTY BUT DO NOT
DRINK
PREFER HOT DRINKS

NORMAL

SLEEP

HARD TO FALL ASLEEP
AWAKE EASILY
RESTLESS
OTHER_____

HARD TO GO BACK TO
SLEEP
LOTS OF DREAMS
NIGHTMARES

TIRED IN THE MORNING
SLEEP TOO MUCH
NORMAL

HEADACHES/DIZZINESS

HEADACHES
VERTIGO
DIZZINESS
MOTION SICKNESS

POOR BALANCE
MIGRAINES
FAINT EASILY
POOR MEMORY

DIZZY IF
STANDING/BENDING
NORMAL

OTHER _____

DIGESTION

INDIGESTION
NERVOUS STOMACH
FULL FEELING
HEARTBURN
NAUSEA/VOMITING
STOMACH NOISES
OTHER _____

BELCH
BLOAT
PAIN/CRAMPS
GAS
BAD BREATH
GALLSTONES

BITTER TASTE
WEIGHT PROBLEMS
GREASY FOOD ISSUES
NORMAL

BOWELS / STOOL

LOOSE STOOL
BLOOD IN STOOL
UNDIGESTED FOOD
DIARRHEA
HEMORRHOIDS
CONSTIPATION
OTHER _____

STOOL W/ BAD SMELL
ANUS ITCH
BURNING ANUS
MUCOUS IN STOOL
COLON PROBLEMS
BLACK STOOL

HARD STOOL
INTESTINAL WORMS
SMALL STOOL
PAIN/CRAMPS
USE LAXATIVES
NORMAL

PERSPIRATION

VERY LITTLE
PROFUSE
EASILY
OTHER _____

NIGHTSWEATS
PALMS
BAD SMELL

FEET
WITHOUT EXERTION
NORMAL

BODY TEMPERATURE

WARM NATURED
FLUSHED FACE
WARMER IN PM
OTHER _____

WARM PALMS
COLD NATURED
CHILLS/FEVER

WARM SOLES
COLD HANDS/FEET
NORMAL

ENERGY

UP & DOWN
LOW
OTHER _____

LOW AFTER EATING
TIRED IN AFTERNOON

EXCESSIVE
NORMAL

HABITS

SMOKING: (amount) _____ cigarettes per day / week

ALCOHOL: (amount) _____ drinks per day / week

RECREATIONAL DRUGS: (type) _____ (amount) _____ per day / week

EXERCISE

NEVER LITTLE MODERATE HEAVY

APPETITE

UP & DOWN POOR GOOD HUNGRY LOSS OF TASTE

WEIGHT

NORMAL UNDERWEIGHT OVERWEIGHT RECENT GAIN/LOSS

FOR MALES:

ARE YOU EXPERIENCING: REDUCED SEX DRIVE PREMATURE EJACULATION OTHER _____	SEMINAL EMISSION IMPOTENCE DISCHARGES GENITAL PAIN PROSTATE PROBLEMS	PAINFUL URINATION DRIBBLE OF URINE
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PLEASE EXPLAIN ANY OR ALL OF THE ABOVE _____

FOR FEMALES:

ARE YOU OR COULD YOU BE PREGNANT? _____
 IF YES, APPROXIMATE DATE OF CONCEPTION _____
 ARE YOU EXPERIENCING REDUCED SEX DRIVE? _____
 OTHER DIFFICULTIES? (PLEASE EXPLAIN) _____

DO YOU HAVE REGULAR PAP TESTS? _____ HOW REGULAR? _____
 DO YOU HAVE EXCESS FACIAL/BODY HAIR? _____

MENSTRUAL CYCLE

AGE BEGAN _____ DAYS OF FLOW _____ AGE STOPPED _____
 HOW MANY DAYS BETWEEN PERIODS? _____

ARE YOUR PERIODS: IRREGULAR PAINFUL HEAVY FLOW CLOTTING SCANTY FLOW LIGHT COLOR DARK COLOR	RETAIN WATER BACKACHE BREAST PAIN BREAST LUMPS SPOT BETWEEN ABDOMEN BLOAT EMOTIONAL SIGH A LOT	CONSTIPATION DIARRHEA TIGHT CHEST HORMONAL PROBLEMS LUMP IN THROAT NORMAL
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EXPLAIN ANY OR ALL OF THE ABOVE _____

MENOPAUSAL FEMALES ONLY:

HOW MANY YEARS HAVE YOU BEEN MENOPAUSAL? _____

SINCE MENOPAUSE, DO YOU EXPERIENCE?:

HOT FLASHES	DEPRESSION	ACNE
MENTAL FOGGINESS	PAINFUL INTERCOURSE	INCREASED VAGINAL PAIN, DRYNESS, OR ITCHING
DISINTEREST IN SEX	SHRINKING BREASTS	
MOOD SWINGS	FACIAL HAIR GROWTH	

STRESS:

PLEASE LIST ANY PHYSICAL OR EMOTIONAL STRESSORS / CAUSES OF ANXIETY IN YOUR LIFE:

PLEASE LIST ANY SIGNIFICAN TRAUMAS (PHYSICAL OR EMOTIONAL), INCLUDING APPROXIMATE DATE:

AS BEST YOU CAN, PLEASE DESCRIBE ANY EMOTIONAL ISSUES YOU'RE FACING RIGHT NOW OR PARTICULAR BEHAVIORAL PATTERNS ABOUT YOURSELF THAT YOU WOULD LIKE TO CHANGE:

HOW DO YOU COPE WITH STRESS?

DO YOU HAVE A DAILY PRACTICE OF SELF-CARE (I.E. JOURNALING, MEDITATION, PRAYER, DEEP BREATHING, STRETCHING)? PLEASE DESCRIBE:

PLEASE RATE THE FOLLOWING ON A SCALE OF 1 - 10, 10 BEING THE BEST AND 1 BEING THE WORST.

	On a scale of 1 – 10...
Your physical health	
Your mental / emotional health	
Your spiritual health	

PLEASE LIST HOW MUCH OF THE FOLLOWING YOU GET PER DAY:

SLEEP (IN HOURS)? _____

WATER (IN OUNCES)? _____

EXERCISE (IN MINUTES)? _____

REST / RELAXATION / RECREATION (IN MINUTES / HOURS)? _____

SUNLIGHT / FRESH AIR / TIME IN NATURE (IN MINUTES / HOURS)? _____

NUTRITION:

PLEASE LIST HOW OFTEN YOU CONSUME THE FOLLOWING FOODS:

	DAILY	WEEKLY	1-2X MONTHLY	NEVER
VEGETABLES				
FRUITS				
WHOLE GRAINS				
BEANS/SEEDS/NUTS				
CHICKEN/TURKEY				
FISH/SEAFOOD				
EGGS				
DAIRY (YOGURT/KEFIR)				
DAIRY (CHEESE/MILK)				
ORGANIC FOODS				
PORK/HAM				
RED MEAT				
SWEETENED JUICE				
CAFFEINE				
GLUTEN / BREAD				
SODA (INCLUDING DIET)				
SUGAR / SUGARY FOODS				
SOY				
CORN				
ALCOHOL				
FRIED FOODS				