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Functional Medicine Case Review

Thank you for contacting us to review your case. Dr. Hedberg is dedicated to helping you achieve optimal health and well-being. Please answer all questions to the best of your ability and return these forms to us by email, fax or regular mail. Your case will be reviewed immediately by Dr. Hedberg and we will contact you to schedule your first appointment if we think we can help you. Please include any lab tests you have had done in the past 2 years. If you need more space, please write more information on another sheet of paper. Please let us know if you have any questions or need help with these forms. We look forward to working with you.

Name:

Date:

Street Address:

City:

State:

Zip Code:

International patients please provide your exact mailing address for shipping.

Phone Numbers:

Work:

Cell:

Home:

What phone number would you like Dr. Hedberg to call you on if you are a virtual patient?

Skype name (If you would like to use Skype):

Email:

Can we add you to Dr. Hedberg's email list for health & practice updates?
Yes or No

Occupation:

Gender:

Age:

Date of Birth:

Height:

Weight:

Marital Status:

Number of Children:

Who referred you/How did you hear about us?

Insurance Company:

Primary Medical Physician Name & Contact Information:

Allergies:

Do you take prescription drugs, including birth control pills (please list)? If taking birth control pills, is it for health reasons or contraception?

Do you have any history of physical trauma or surgeries (list surgeries)? Have you ever had your tonsils, appendix, or gall bladder removed?

Describe a brief history of your dental health including mercury-containing amalgams/fillings, infections, root canals etc.:

Do you smoke?

Have you ever smoked?

What is your current stress level on a scale of 1-10 (1 is low stress):

List pets:

Do you currently or have you ever lived with someone who smoked, even as a child?

Please list any supplements you are currently taking:

Tell me about your chief complaint(s)

What is your opinion of what has happened to your health?

Can you think of any predisposing factors such as genetic or environmental issues that could be related to your illness?

Can you think of anything that triggered your condition/symptoms?

Do you know what is perpetuating/contributing to your condition?

How many hours do you sleep at night?
Do you have trouble falling asleep?
Do you wake up in the middle of the night?

Tell me about your exercise habits now and in the past?

Do you follow a specific diet or nutrition plan such as vegan, vegetarian, paleo etc.?

Do you think that stress is part of your condition?

Are there any stressful or “toxic” relationships in your life that could be wearing you down?

Do you experience anxiety, depression or other mood imbalances (anger, grief, sadness)?

Do you have issues with brain fog, short or long-term memory?

If you suffer from fatigue, does your day have a particular pattern of when energy is highest and lowest?

Do you get sick easily such as colds or the flu?

What is your family history of disease such as heart disease, cancer, diabetes etc.?

Are there any treatments, medications, supplements etc. that have helped you with your health?

Have you ever had exposure to environmental, industrial or toxic compounds?

Please list your history of infections:

Have you ever used prescription drugs at any time in the past, i.e., antibiotics during childhood?

Have you ever been bitten by a tick and if so, was there a rash?

Have you ever lived somewhere that contained mold?

Do you have any history of miscarriages?

Do you consume alcoholic beverages? If so, how much? What was your frequency of alcoholic beverage intake at any time in the past?

Do you consider yourself overweight, underweight, or ideal weight?

Do you live in an urban or rural area?
Is your water source city or well and is it purified?

Who do you live with?

Tell me about your job:

Do you work second or third shift?

Tell me about your hobbies?

Do you have problems with constipation or diarrhea? How often per day do you have bowel movements? If a digestive problem exists, how long has it persisted?

Do you have any problems with urination relating to frequency or pain? If so, how long?

Do you have ongoing pain in any part of your body? If so, how long?

Have you used recreational drugs at any time in the past? If so, what was used, how long was it used, and what was the frequency?

Do you currently use recreational drugs?

Have you ever traveled to foreign countries, including Mexico? If so, did you ever suffer from "Montezuma's revenge" or any other GI disturbances?

What was the health of your mother during your pregnancy?

Did either of your parents smoke or ingest significant amounts of alcohol before, during, or after the pregnancy?

Do you know if the delivery was difficult?

Were you delivered via vaginal birth or Caesarian section?

What was your overall health status during your first five years of age?

List any childhood illnesses:

What was your family life like during your first five years of age?

Were you a happy child during the first five years of age?

Tell me about all your previous jobs?

Did you ever have any type of eating disorder such as bingeing or purging?

How fast do you eat? What do you think about when you eat? Do you ever eat standing or "on the run?"

Do you feel like you have meaning and purpose in your life?

Is there anything else I should know about you that we have not yet discussed?

How did you feel about answering these questions?

Thank you for filling out these forms. Please email them to admin@drhedberg.com or fax to: 206-339-7192