FUNCTIONAL MEDICINE FLORIDA

3982 Bee Ridge Road, Suite J • Sarasota, FL 34233
Call: 941-929-9355 Fax: 941-927-4914

Welcome to Functional Medicine Florida!

We are honored that you have chosen Functional Medicine Florida for your health, wellness and supplement provider. We look forward to meeting you and providing you with the highest level of personalized wellness care to help you achieve optimal health.

Dr. Harvey has served in the community since 1996 as a skilled physician with over 30 years of medical experience, including 16 years of functional and holistic medicine. He is quadruple board-certified in Internal Medicine, Geriatric Medicine, Functional Medicine, and Holistic-Integrative Medicine, specializing in chronic illness recovery & prevention and defiant aging. He also has been voted the areas "Favorite Holistic Doctor" three years running in Natural Awakenings magazine.

We also specialize in Chelation therapy & IV nutritionals. In addition, we host a licensed Functional Health Coach, a Heart Math Clinician and Trauma Practioner. We provide the highest nutraceutical supplements from companies such as Xymogen, Neuroscience, Metagenics and Ortho Molecular Products to meet our patient's needs. We also have a full time Supplement Specialist to answer your questions in person, over the phone, or to ship your supplements to you.

Here are some simple tips that help us make your visit most effective:

- Please return your registration form and medical release forms two weeks prior to your appointment
- Arrive 15 minutes prior to appointment and check in at the front desk**.**
- Bring your new patient/physical paperwork completed**.**
- Please bring any medication bottles and supplement bottles you are currently taking**.**
- Plan for visit to last 1-3 hours, depending on your customized need**s.**
- Due to the health concerns arising from exposure to scented products, **Functional Medicine Florida** has instituted a scent-free environment policy. Please do not use scented products such as perfumes, body sprays, lotions, and hair products while in the office. Thank you for your understanding.

We ask that you please notify our office 48 hours prior to your appointment or lab draw if you need to cancel or reschedule. If we do not receive a 48 hour cancelation notice, you will be charged for your appointment.

As a reminder, Dr. Harvey does not accept any commercial insurance or participate in any Medicare plan. If you are a Medicare part B participant and wish to become Dr. Harvey's patient, you are required to accept the terms and conditions set forth by our office and sign a contract. Neither you nor Dr. Harvey can bill for any reimbursement from Medicare for his services provided. However, we can provide a detailed receipt with proper coding for services performed which you can submit to your commercial insurance company.

At **Functional Medicine Florida**, we believe that "Functional Medicine is a new paradigm and encourage patients to be involved and responsible for their health." To assist you in reaching this goal, Dr. Harvey has chosen HelloHealth as a safe and convenient way for his patients to receive optimal care and recording keeping. HelloHealth is an Electronic Health Records system that gives you the ability to access your records, send messages and have access to any test results online securely 24 hours a day. You will be given a 30 day free trial from HelloHealth when you become a patient. The cost after the 30 day trial will be an annual fee of $69.00 per person or $99.00 for a family plan. **If you commit to a one year office package it will be included at no cost.**

Once again, thank you for choosing **Functional Medicine Florida.** The entire staff is now on your wellness team. Please do not hesitate to let us know how we can best serve you!

To Your Health & Happiness,

Fred Harvey, MD & Staff

FUNCTIONAL MEDICINE FLORIDA

Dear Valued Patient,

We hope this letter finds you in good health and high spirits. As part of our commitment to providing you with comprehensive healthcare services, we would like to clarify the role of Dr. Fred Harvey at our clinic.

Dr. Fred Harvey is a highly skilled and experienced preventative Functional Wellness Doctor. He specializes in proactive approaches to health and focuses on optimizing overall well-being by emphasizing lifestyle changes, nutrition, exercise, and stress management. His expertise lies in preventive measures and supporting the body's natural healing processes through functional medicine principles.

It is important to note that Dr. Fred Harvey is not a primary care physician and does not provide the full spectrum of primary care services typically associated with a traditional family doctor. While he can guide and support you in achieving optimal health and wellness, his role primarily revolves around preventative care and enhancing your overall quality of life.

By signing below, you acknowledge and understand that:

1. **Dr. Fred Harvey is a preventative Functional Wellness Doctor specializing in proactive health measures and optimizing well-being.**
2. **He provides guidance on lifestyle modifications, nutrition, exercise, stress management, and functional medicine principles.**
3. **Dr. Fred Harvey is NOT a primary care physician and does not provide the full range of primary care services.**

We kindly request your signature below to confirm your understanding of Dr. Fred Harvey's role and responsibilities as a preventative Functional Wellness Doctor. If you have any questions or require further clarification, please do not hesitate to contact our clinic at 941-929-9355 or via email at info@functionalmedicineflorida.com

Thank you for entrusting us with your healthcare needs, and we look forward to supporting you on your journey toward optimal health and wellness.

Sincerely,
Functional Medicine Florida Team

Signature _____ Date: _____

FUNCTIONAL MEDICINE FLORIDA

PATIENT REGISTRATION

Patient Name _____ D.O.B. _____ SS# _____

Street address _____

City _____ State _____ Zip _____

Tel# Home _____ Cell _____ Work _____

E-Mail Address _____

Spouse/Partner Name _____ Tel# _____

Emergency contact _____ _____

Patient's Occupation _____

Employer Name _____ Tel# _____

Employer Street Address _____

City _____ State _____ Zip _____

Northern Address _____

City _____ State _____ Zip _____

Northern Phone# _____

INSURANCE

Primary Insurance/Medicare

Name _____

ID# _____ Group# _____ Phone# _____

Secondary Insurance

Name _____

ID# _____ Group# _____ Phone# _____

FUNCTIONAL MEDICINE FLORIDA

3982 Bee Ridge Road, Suite J • Sarasota, FL 34233

Our office is in compliance with the Health Insurance Portability and Accountability Act. Our policies and procedures in regards to privacy will be enforced. You have received a copy of our privacy practices, please review it and complete the following:

Please read and initial each statement below:

_____ I have received a copy of this office's Notice of Privacy Practices.

_____ I understand that this office will leave messages on my voicemail or at the number that I provided to remind me of appointments. I also understand that a message may be left asking me to contact the office.

_____ I understand that I may request this office to contact me by alternate means.

_____ I understand that uses and disclosures of my protected health information may be made for treatment, payment and the operations of this practice.

_____ I understand that I must provide this office a copy of Power of Attorney papers or Health Care Surrogate papers if applicable.

_____ I understand that I must provide additional written authorization for any other disclosure.

_____ I understand that Dr. Fred Harvey and his staff will not discuss my medical condition or treatment with anyone, including my spouse, unless I have authorized them to do so. I give permission to Dr. Fred Harvey and his staff to **discuss** my protected health information **with** the below listed people:

1. Na _____ Relationship _____

DOB _____ Phone Number _____ Gender _____

2. Name _____ Relationship _____

DOB _____ Phone Number _____ Gender _____

3. Name _____ Relationship _____

DOB _____ Phone Number _____ Gender _____

(Any changes to the above listed individuals must be provided in writing)

_____ I understand that my treatment will not be conditioned upon refusal to sign this notice.

Date _____

Signature _____ Printed Name _____

Witness _____

FUNCTIONAL MEDICINE FLORIDA

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (Last, First, Middle Initial):		
Patient Address:		
City:	State:	Zip Code:
Telephone #:	Date of Birth:	

I authorize release/disclosure of the patient's health records and information:

From the health care provider, physician, office facility as listed below:	**From** the health care provider, physician, office facility as listed below:
Name:	Name:
Address/City/State/Zip:	Address/City/State/Zip:
Telephone #:	Telephone #:
Health Care Provider Fax # (if applicable):	Health Care Provider Fax # (if applicable):
From the health care provider, physician, office facility as listed below:	**From** the health care provider, physician, office facility as listed below:
Name:	Name:
Address/City/State/Zip:	Address/City/State/Zip:
Telephone #:	Telephone #:
Health Care Provider Fax # (if applicable):	Health Care Provider Fax # (if applicable):

To the patient, personal representative, health care provider, physician, office, facility as listed below:

I authorize release/disclosure of the following health information during the term of this Authorization: ***(Initial all that apply):***

- ☐ Entire Medical Record
- ☐ Specific Date of Service _____/_____/_____
- ☐ Specific Date Range _____/_____/_____
- ☐ Imaging/Radiology Films (Specify date or date range)_____
- ☐ Hospitalization (H & P, Consult, Tests, Surgical, Discharge Summary)
- ☐ Test Results (Specify: Lab, X-Ray, EKG, etc.)_____
- ☐ Therapy Notes (Specify: PT, OT, Speech, etc.)_____
- ☐ Other:_____

The purpose of the disclosure is: ***(Initial all that apply):***

☐ Continuation of Care
☐ Changing Healthcare Providers
☐ Personal Reasons (at the request of the individual)
☐ Insurance
☐ Second Opinion/Consult
☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you don't authorize the disclosure of the following information, which may be included in the health information listed above. ***(Check all that apply):***

☐ STD / HIV / AIDS	☐ Alcohol, Drug, or Substance Abuse	☐ Mental Health	☐ Genetic Data

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Expiration of Authorization:

This authorization will remain in force and effect under the following conditions: ***(Initial all that apply):***

☐ From the date of this Authorization until the following date: _____/_____/_____

☐ Until the happening of the following expiration event:

If I do not specify any expiration date or event, then this Authorization will expire twelve (12) months from the date on which I sign the Authorization.

I understand that, as set forth in The Harvey Center for Integrative Medicine Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending notification to:

Functional Medicine Florida
3982 Bee Ridge Road, Suite J
Sarasota, FL 34232

- I understand my revocation will not apply to information already retained, used or disclose in response to this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the office will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that I have the right to:
  - Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
  - Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

Official Use Only

Completed/Witnessed by: _____ (Print Full Name) Date Completed: _____

Delivery method : ☐ FAXED TO THE HEALTHCARE PROVIDER ☐ MAILED

FUNCTIONAL MEDICINE FLORIDA

NOTICE OF PRIVACY PRACTICES

EFFECTIVE JANUARY 1, 2015

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also describes your rights to access and control your protected health information. "Protected health information" is information, that may identify you and that relates to your past, present and future physical, mental health or condition and related healthcare services.

Federal law requires us to abide by the terms of the Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain. We will provide you with any revised Notice of Privacy Practices upon request.

Uses and Disclosures of Protected Health Information

The use and disclosure of your protected health information will be used for treatment, payment and health care operation. Your protected health information may be used and disclosed by your physician, his staff and others outside of our office that are involved in you care and treatment for the purpose of providing health care services to you. Your protected health information will also be used and disclosed to pay your health care bills and to support the operations of this practice.

Following are example of the types of uses and disclosures of your protected health information that our office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made.

Uses and Disclosues of Protected Health information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information as described below will be made only with your written authorization, unless otherwise permitted or required by law. Your authorization will be required each time disclosure of your protected health information is made for uses other than treatment, payment or healthcare operations.

Disclosure of any health information related to HIV test orders or results will not be released without your written authorization.

Permitted and Required Uses and Disclosure That May Be Made Without Your Consent or Authorization

For the purpose of public health and safety as required by state and federal law. This includes disclosure of health information relating to communicable diseases.

For the purpose of patient and minor patient safety as required by state law. We may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

For the purpose of reporting adverse drug reactions, product defects, biologic product deviations and to enable product/drug recalls as required by the Food and Drug Administration.

For the purpose of any judicial or administrative proceedings, or in response to an order of a court or administrative tribunal or in certain conditions in response to a subpoena, discovery request or other lawful process.

For the purpose of law enforcement as applicable by legal requirements. This information includes limited information requests for identification and location purposes, information pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct and in the even that a crime occurs on the premises of the practice. We may also disclose your protected health information if we believe it is necessary to prevent or lesson a serious or imminent threat to the health or safety of a person or the public.

For the purpose of identification, cause of death or other investigation as performed by the coroner or medical examiner. We may also disclose such information in the reasonable anticipation of death.

For the purpose of military activity and national security as commanded by military authorities.

For the purpose of Worker's Compensation as required by law.

For the purpose of Health Oversight we may disclose protected health information as required by law to government agencies that oversee the health care system, government benefit programs and other government regulatory programs. This includes audits of billing records and investigation and inspection of your medical records.

Individual Rights

You have the right to inspect and obtain a copy of your protected health information. You may inspect and obtain a copy of your protected health information about you that is contained in your record for as long as we maintain the protected health information. This information includes all medical and billing records and the practice uses for making decisions about you. There is a fifty cent per page charge for medical records beyond the first twenty pages.

Under federal law however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Also, your physician also has the right to exercise professional judgment if it is felt that the release of protected health information may endanger the life or physical safety of the individual or another person. Depending on the circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of your protected health information.

You may ask us not to use or disclose any part of your protected health information for purpose of treatment, payment or healthcare operations. Your physician is not required to agree to a restriction that you request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree, we may not use or disclose your protected health information in violation of the stated restriction unless it is needed to provide emergency treatment. Please discuss any restrictions request with our privacy officer.

You have the right to receive confidential communications from us by alternative means.

You may request that we contact you at an alternative address of phone number. You must provide us with an explanation of this request and the request will be considered.

Your request must include alternate address, phone number and information as to how payment will be handled. We will accommodate reasonable requests.

You have the right to have your physician amend your protected health information.

You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases we may deny your request for amendment. You have the right to file a statement of disagreement with us and we pay prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an account of certain disclosures we have made, if any, of your protected health information.

This right applies to disclosures for the purposes than treatment, payment or healthcare operations as described in this policy.

You have to right to obtain a paper copy of this notice. You have the right to file a complaint.

You may file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

This notice was published and becomes effective April 14**, 2023**

Agreement By Medicare Beneficiary For Medical Services

Date: _____ Time: _____

_____ , a patient and Medicare Part B Beneficiary ("Patient"), and Fred Harvey, M.D., P.A. a physician licensed to practice medicine in Florida ("Physician"), enter into this agreement for the provision of medical services specified herein ("Services") in accordance with the provisions of Section 4507 of the Balanced Budget Act of 1997. Wherefore, in exchange for consideration, the receipt and sufficiency of which the Parties hereby acknowledge; Patient and Physician agree as follows:

1. Patient acknowledges and agrees that this Agreement has been entered into, and that Patient has received a copy of this Agreement before Physician has provided the services specified herein to Patient.

2. Patient acknowledges and agrees that this Agreement has not been entered *into* at a time when Patient is facing an emergency or urgent health care situation.

3. The services to be provided to Patient are: medical and physician services, ancillary health services, diagnostic testing, and office visits (collectively referred to hereinafter as "Services).

4. Patient agrees not to submit a claim (or request that Physician submit a claim on Patient's behalf) under the Social Security Act, as amended (42 U.S.C. § 1395a), for the Services, even if such Services are otherwise covered under Medicare Part B.

5. Patient agrees to be personally responsible, whether through private insurance or otherwise, for the payment of Services.

6. Patient acknowledges that Medicare will not provide reimbursement for the Services and that no Medicare fee limits (including those specified in 42 U.S.C. § 1395a: 1848(g) will apply to the amount Physician charges for Services.

7. Patient acknowledges that Medigap plans under 42 U.S.C. § 1882 do not, and other supplemental insurance plans may not, make payments for the Services.

8. Patient acknowledges that, as a Medicare beneficiary, Patient has the right to have the Services provided by other physicians or practitioners who have not opted-out of Medicare and for whom payment would be made under 42 U.S.C. § 1395a. Patient acknowledges that he or she is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

9. Physician has informed Patient that Physician is not excluded from participating in Medicare Part B under 42 U.S.C. § 1128, 1156, or 1892 or any other section of the Social Security Act.

10. By signing this contract Patient understands that Medicare payment will not be made for any items or services furnished by the physician or practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

11. Physician filed an affidavit with Medicare effective on September 1, 2016. Opt-out affidavits signed on or after June 16, 2015 will automatically renew every two years.

Signature of Patient _____ Date _____

Witness _____

Signature of Physician _____ Date _____

Witness _____

FUNCTIONAL MEDICINE FLORIDA

MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name _____ Middle _____ Last _____

Street Address _____

City _____ State _____ Zip _____

Tel# Home _____ Cell _____ Work _____

Birth Date _____/_____/_____ Age _____ Place of Birth _____

Occupation _____

Referred By _____

Height _____ ' _____" Weight _____ Sex _____

Today's Date _____

Current Healthcare Practitioners

1. Name _____ Tel/Fax _____

2. Name _____ Tel/Fax _____

3. Name _____ Tel/Fax _____

1. Please check appropriate box: ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian ❑ Native American ❑ Caucasian ❑ Northern European ❑ Other

2. Please rank current and ongoing problems ***by*** priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 47, sister

_____ _____

_____ _____

4. Do you have any pets or farm animals? ❑ Yes ❑ No

If yes, where do they live? ❑ indoors ❑ Outdoors ❑ Both indoors and outdoors

5. Have you lived or traveled outside of the United States? ❑ Yes ❑ No

If so, when and where? _____

_____

6. Have you or your family recently experienced any major life changes? ❑ Yes ❑ No

If yes, please comment: _____

_____

7. Have you experienced any major losses in life? ❑ Yes ❑ No

If so, please comment: _____

_____

8. How important is religion (or spirituality) for you and your family's life?

❑ not at all important ❑ somewhat important ❑ extremely important

9. How much time have you lost from work or school in the past year?

❑ 0-2 days ❑ 3 –14 days ❑ 15 days

10. Previous jobs: _____

_____

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Did you feel safe growing up? ❑ Yes ❑ No

Have you been involved in abusive relationships in your life? ❑ Yes ❑ No

Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? ❑ Yes ❑ No

Do you currently feel safe in your home? ❑ Yes ❑ No

Do you feel safe, respected and valued in your current relationship? ❑ Yes ❑ No

Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? ❑ Yes ❑ No

Would you feel safer discussing any of these issues privately? ❑ Yes ❑ No

Do you own guns? If so , are they safely stored to prevent home tragedies? ❑ Yes ❑ No

12. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Back Injury		
	Broken (describe)		
	Cancer		
	Chronic Fatigue Syndrome		
	Crohn's Disease or Ulcerative Colitis		
	Diabetes		
	Emphysema		
	Epilepsy, convulsions, or seizures		
	Gallstones		
	Gout		
	Head Injury		
	Heart attack/Angina		
	Heart failure		
	Hepatitis		
	High blood fats (cholesterol, triglycerides)		
	High blood pressure (hypertension)		
	Irritable bowel		
	Kidney stones		
	Mononucleosis		
	Pneumonia		
	Rheumatic fever		
	Sinusitis		
	Sleep apnea		
	Stroke		
	Thyroid disease		
	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
	Barium Enema		
	Bone Scan		
	CAT Scan of Abdomen		
	CAT Scan of Brain		
	CAT Scan of Spine		
	Chest X-Ray		
	Colonoscopy		
	EKG		
	Liver Scan		
	Neck X-Ray		
	NMR/MRI		
	Sigmoidoscopy		
	Upper GI Series		
	Other (describe)		

	OPERATIONS	WHEN	COMMENTS
	Appendectomy		
	Dental Surgery		
	Gall Bladder		
	Hernia		
	Hysterectomy		
	Tonsillectomy		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

14. How often have you taken antibiotics?

	< 5 TIMES	> 5 TIMES
Infancy / Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 TIMES	> 5 TIMES
Infancy / Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

MEDICATION NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list: _____

_____

Do you have sensitivities or allergies to any environmental substances? (pollen, foods, dyes, etc.) ❑ Yes ❑ No

If yes, please list: _____

17. List **all** vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

VITAMIN/MINERAL/SUPPLEMENT NAME	DATE STARTED	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

USUAL BREAKFAST	√	USUAL LUNCH	√	USUAL DINNER	√
None		None		None	
Bacon/Sausage		Butter		Beans (legumes)	
Bagel		Coffee		Brown rice	
Butter		Eat in a cafeteria		Butter	
Cereal		Eat in a restaurant		Carrots	
Coffee		Fish sandwich		Coffee	
Donut		Juice		Fish	
Eggs		Leftovers		Green vegetables	
Fruit		Lettuce		Juice	
Juice		Margarine		Margarine	
Margarine		Mayo		Milk	
Milk		Meat Sandwich		Pasta	
Oat bran		Milk		Potato	
Sugar		Salad		Poultry	
Sweet roll		Salad dressing		Red meat	
Sweetener		Soda		Rice	
Tea		Soup		Salad	
Toast		Sugar		Salad dressing	
Water		Sweetener		Soda	
Wheat bran		Tea		Soup	
Yogurt		Tomato		Sugar	
Other (List below)		Water		Sweetener	
		Yogurt		Tea	
		Other (List below)		Water	
				Yellow vegetables	
				Other (List below)	

19. Childhood:

QUESTIONS	YES	NO	DONT KNOW	COMMENT
1. Where you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

20. As a child, were there any foods that you had to avoid because they gave you symptoms? ❑ Yes ❑ No

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

_____

21. How much of the following do you consume each week?:

Candy		Diet sodas	
Cheese		Ice cream	
Chocolate		Salty foods	
Cups of coffee containing caffeine		Slices of white bread (rolls/bagels)	
Cups of decaffeinated coffee or tea		Sodas with caffeine	
Cups of hot chocolate		Sodas without caffeine	
Cups of tea containing caffeine			

22. Are you on a special diet? ❑ Yes ❑ No

❑ ovo-lacto ❑ vegetarian ❑ diabetic ❑ vegan ❑ dairy restricted

❑ blood type diet ❑ paleo: ❑ ketogenic: ❑ other (describe):

23. Is there anything special about your diet that we should know? ❑ Yes ❑ No

If yes, please explain _____

_____

24. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ❑ Yes ❑ No

b. If yes, are these symptoms associated with any particular food or supplement(s)? ❑ Yes ❑ No

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_____

25. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ❑ Yes ❑ No

26. Do you feel much worse when you eat a lot of :

_____ high fat foods _____ refined sugar (junk food)

_____ high protein foods _____ fried foods

_____ high carbohydrate foods _____ 1 or 2 alcoholic drinks

_____ (breads, pastas, potatoes) _____ other _____

27. Do you feel much better when you eat a lot of :

_____high fat foods
_____high protein foods
_____high carbohydrate foods
_____(breads, pastas, potatoes)
_____ refined sugar (junk food)
_____ fried foods
_____ 1 or 2 alcoholic drinks
_____ other _____

28. Does skipping a meal greatly affect your symptoms? ❑ Yes ❑ No

29. Have you ever had a food that you craved or really "binged" on over a period of time? ❑ Yes ❑ No
Food craving may be an indicator that you may be allergic to that food.

If yes, what food(s)? _____

30. Do you have an aversion to certain foods? ❑ Yes ❑ No

If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

FREQUENCY	√	COLOR	√	CONSISTENCY	√
More than 3x / day		Medium brown consistently		Soft and well formed	
1-3x / day		Very dark or black		Often float	
4-6x / day		Greenish color		Difficult to pass	
2-3x / week		Blood is visible		Diarrhea	
1 or few x / week		Varies a lot		Thin, long or narrow	
		Dark brown consistently		Small and hard	
		Yellow, light brown		Loose but not watery	
		Greasy, shiny appearance		Alternating between hard and loose/ watery	

32. Intestinal gas:
_____ Daily
_____ Occasionally
_____ Excessive
_____ Present with pain
_____ Foul smelling
_____ Little odor

33. a. Have you ever used alcohol? ❑ Yes ❑ No

b. If yes, how often do you now drink alcohol?
____ Average 1-3 drinks per week
____ Average 4-6 drinks per week
____ Average 7-10 drinks per week
____ Average >10 drinks per week
_____ No longer drinking alcohol

c. Have you ever had a problem with alcohol? ❑ Yes ❑ No

If yes, please indicate time period (month/year): From _____ to _____

34. Have you ever used recreational drugs? ❑ Yes ❑ No

35. Have you ever used tobacco? ❑ Yes ❑ No

If yes, number of years as a nicotine user _____ Amount per day _____ Year quit _____

If yes, what type of nicotine have you used? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum

36. Are you exposed to second hand smoke regularly? ❑ Yes ❑ No

37. Do you have mercury amalgam fillings? ❑ Yes ❑ No

38. Do you have any artificial joints or implants? ❑ Yes ❑ No

39. Do you feel worse at certain times of the year? ❑ Yes ❑ No

If yes, when? ❑ spring ❑ fall ❑ summer ❑ winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? ❑ Yes ❑ No

If yes, which one(s)? ❑ lead ❑ cadmium ❑ arsenic ❑ mercury ❑ aluminum

41. Do odors affect you? ❑ Yes ❑ No

42. How well have things been going for you?

		VERY WELL	FAIR	POORLY	VERY POORLY	DOES NOT APPLY
	At school					
	In your job					
	In your social life					
	With close friends					
	With sex					
	With your attitude					
	With your boyfriend/girlfriend					
	With your children					
	With your parents					
	With your spouse					

43. Are you currently, or have you ever been, married? ❑ Yes ❑ No

If so, when were you married? _____ Spouse's occupation _____

When were you separated? _____ ❑ Never

When were you divorced? _____ ❑ Never

When were you remarried? _____ ❑ Never Spouse's occupation _____

Comments: _____

_____

44. Hobbies and leisure activities: _____

_____

45. Do you exercise regularly? ❑ Yes ❑ No

If so, how many times a week?

1. ❑ 1x
2. ❑ 2x
3. ❑ 3x
4. ❑ 4x or more

When you exercise, how long is each session?

1. ❑ <15 min
2. ❑ 16-30 min
3. ❑ 31-45 min
4. ❑ > 45 min

What type of exercise is it?

❑ jogging/walking ❑ tennis ❑ basketball ❑ water sports ❑ home aerobics

❑ other _____

46.

FAMILY HISTORY: For each member of your family, follow the grey or white line across this page and check the boxes for:
1. Their present state of heath, and
2. Any illnesses they have had

(Note: Except for spouse, Family refers to blood or natural relatives.)	Good	Poor	Deceased	Write in age and cause of death. Include accidents and suicides	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia?	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epi-lepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father:																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child																			
Child:																			
Child:																			
Paternal relatives (in each box, write in how many affected with condition):																			
Maternal relatives (in each box, write in how many affected with condition):																			

47. Any other family history we should know about? ❑ Yes ❑ No

If so, please comment:_____

_____

48. What is the attitude of those close to you about your illness?

❑ Supportive ❑ Non-Supportive

FOR WOMEN ONLY (questions 49-57):

49. Have you ever been pregnant? (If no, skip to question 53.) ❑ Yes ❑ No

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? ❑ Yes ❑ No

Have you had other problems with pregnancy? ❑ Yes ❑ No

If so, please comment: _____

_____

50. Age of first period _____ Date of last pap smear _____ Date of last mammogram _____

Pap Smear: ❑ Normal ❑ Abnormal

Mammogram: ❑ Normal ❑ Abnormal

51. Have you ever used birth control pills? ❑ Yes ❑ No If yes, when? _____

52. Are you taking the pill now? ❑ Yes ❑ No

53. Did taking the pill agree with you? ❑ Yes ❑ No ❑ Non Applicable

54. Do you currently use contraception? ❑ Yes ❑ No

If yes, what type of contraception do you use? _____

55. Are you in menopause? ❑ Yes ❑ No If yes, age at last period: _____

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Progesterone ❑ Provera

❑ Other _____

56. How long have you been on hormone replacement therapy (if applicable)? _____

57. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?

❑ Yes ❑ No ❑ Non Applicable

Please Check all that apply:

GENERAL	MILD	MODERATE	SEVERE
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			
MUSCULOSKELETAL			
Back muscle spasms			
Calf cramps			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches around eyes			
Muscle twitches arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			

MOOD / NERVES	MILD	MODERATE	SEVERE
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black out			
Depression			
Difficulty concentrating			
with balance			
with thinking			
with judgement			
with speech			
with memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Numbness			
Other phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			

DIGESTION	MILD	MODERATE	SEVERE
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of lower abdomen			
whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			

SKIN PROBLEMS	MILD	MODERATE	SEVERE
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's Foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w/ color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF	MILD	MODERATE	SEVERE
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES	**MILD**	**MODERATE**	**SEVERE**
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS	**MILD**	**MODERATE**	**SEVERE**
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of finger nails			
Toenails			
White spots/lines			
RESPIRATORY	**MILD**	**MODERATE**	**SEVERE**
Bad breath			
Bad odor in nose			
Cough-dry			
Cough-productive			
Hay fever: Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			

RESPIRATORY, CONT'D	MILD	MODERATE	SEVERE
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR	**MILD**	**MODERATE**	**SEVERE**
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			
URINARY	**MILD**	**MODERATE**	**SEVERE**
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE	MILD	MODERATE	SEVERE
Breast cysts			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			

Any other information you'd like to share with Dr. Harvey?

FUNCTIONAL MEDICINE FLORIDA

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

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
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight **Total** _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities **Total** _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **Total** _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **Total** _____

Grand Total _____

FUNCTIONAL MEDICINE FLORIDA

FOOD DIARY

Patient Name & Date _____

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Breakfast							
Lunch							
Dinner							
Snack							
Snack							
Exercise							