

**Nikolas R. Hedberg, D.C., D.A.B.C.I.
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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 immediately reviewed 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 and utilize the request for medical records form as needed.

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:

Address:

Phone Numbers:

Work:

Cell:

Home:

Email:

Can we add you to Dr. Hedberg's email list for health & practice updates?

Occupation:

Gender:

Age:

Date of Birth:

Marital Status:

Number of Children:

Who referred you?

Social Security #:

Insurance Company:

Primary Medical Physician Name & Contact Information:

Allergies:

Do you smoke?

Have you ever smoked?

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

List pets:

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

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

Please list any natural supplements your are currently taking:

Tell me about your chief complaint(s)

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

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?

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

Please list your history of infections:

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

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

Have you ever been bitten by a tick?

Have you ever lived somewhere that contained mold?

Do you have any history of miscarriages or abortion?

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 a urban or rural area?
Is your water source city or well and is it purified?

Who do you live with?

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 job:

Do you work second or third shift?

Tell me about your hobbies?

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

Do you have problems with constipation or diarrhea? How often per day do you have bowel movements? If a 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?”

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

How did you feel about answering these questions?

GLUTEN QUESTIONNAIRE

Gluten intolerance has been found to be most common among people of Irish, English, Scottish, Scandinavian, and Eastern European. Often times it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process, which affects an alarming percentage of the population. The most significant symptoms are **weight gain, fatigue and depression**.

The following test is a diagnostic tool to help you to understand the symptoms and signs that are likely to go along with gluten intolerance.

Test Interpretation Guide (combine both sections)

Number of "Yes" Responses	=	Potential for Gluten Intolerance
4 or less	=	Not likely
5 - 8	=	Suspected
9 or more	=	Very likely

Do any of the following apply to you?

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty relaxing, feel tense frequently
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Female hormone imbalances, (PMS, menopausal symptoms)
<input type="checkbox"/>	<input type="checkbox"/>	Muscle or joint pain or stiffness of unknown cause
<input type="checkbox"/>	<input type="checkbox"/>	Migraine like headaches
<input type="checkbox"/>	<input type="checkbox"/>	Food allergies/sensitivities
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty digesting dairy products
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to over consume alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Overly sensitive to physical and emotional pain, cry easily
<input type="checkbox"/>	<input type="checkbox"/>	Cravings for sweets, bread, carbohydrates
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to overeat sweets, bread, carbohydrates
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain or cramping
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating or distention
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal gas
<input type="checkbox"/>	<input type="checkbox"/>	"Love" specific foods
<input type="checkbox"/>	<input type="checkbox"/>	Eat when upset, eat to relax
<input type="checkbox"/>	<input type="checkbox"/>	Constipation or diarrhea of no known cause
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained skin problems/rashes

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 Difficulty gaining weight

Have you suffered from any of the following conditions?

Yes	No	
		Allergies
		Depression
		Anorexia
		Bulimia
		Rosacea
		Diabetes
		Osteoporosis/bone loss
		Iron deficiency/anemia
		Chronic fatigue
		Irritable bowel syndrome
		Crohn's disease
		Ulcerative colitis
		Candida
		Hypoglycemia
		Lactose intolerance
		Alcoholism

Important Practice Information

Cancellation Policy

We have a 24-hour cancellation policy. You must contact our office within 24 hours to cancel or reschedule your appointment or you will be charged for that appointment. We understand that there are unpredictable occurrences in life that cannot be helped so please contact us to explain your unique situation and the fee may be waived.

If you are going to be more than 15 minutes late to your appointment then call us to reschedule. We do our best to respect every patient's appointment and time so if the appointment is going to run-over into another it must be changed.

Fee Schedule

Our fee schedule is simple and straightforward. Please don't hesitate to contact us with questions. Here are the basic guidelines:

-Payment is expected at time of service. You will be given an invoice with diagnosis and procedure codes which you can file to your insurance company. We are "out of network" with all insurance companies so you will be reimbursed directly by your insurance company for services that are covered.

-We accept Visa, MasterCard, American Express, Discover, Care Credit, Checks and Cash. There is a \$15.00 charge for returned checks.

-Level 1 Consultation: Brief Visit/Phone Call	\$49.00
-Level 2 Consultation: Routine Visit/Phone Call	\$65.00
-Level 3 Consultation: Intermediate Visit/Phone Call	\$98.00
-Level 4 Consultation: Complex Visit/Phone Call w/Labs	\$146.00
-Level 5 Consultation: Complex Visit/Phone Call w/Blood Chemistry	\$195.00

-If you pay cash for a lab test, the consultation is included in the cost of the test so there is no charge for the follow-up consultation.

Email Policy

Dr. Hedberg does not communicate with patients via email. All communications should be sent to the office manager at info@drhedberg.com or call 828-254-4024. We have hundreds of active patients and Dr. Hedberg cannot possibly take emails whenever there is a question as he would be overwhelmed. Please write down all questions and bring them to your next appointment or schedule a brief phone consult with Dr. Hedberg. If you are having a bad reaction to the treatment plan please call the office manager and the questions will be relayed to Dr. Hedberg immediately. You will get a response asap. Thank you for understanding.

Supplement Policy

Dr. Hedberg spends a great deal of time researching the highest quality and most effective supplements available. If you ever have a bad reaction to a supplement that Dr. Hedberg prescribes you can always bring it back for a full refund or exchange it for another supplement that your body can tolerate better. Supplements that are great than 6 months old cannot be returned.

Cell Phone Policy

Please turn off your cell phone while you are in session with Dr. Hedberg as a courtesy to the doctor, staff and other patients.

Perfumes

As a courtesy to our patients that have chemical sensitivities, we ask that you, and anyone that comes with you, please not wear any perfumes, colognes or other toiletries any time you come to our office. Thank you.

Credentials

Dr. Hedberg is a licensed Chiropractic Physician in North Carolina and a Board Certified Chiropractic Internist by the ABCI (American Board of Chiropractic Internists). Dr. Hedberg is not a medical doctor or osteopathic physician. Dr. Hedberg will always refer you to a medical physician when appropriate.

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Request for Records

Patient's Name: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Telephone Number: _____

Requesting Records of Doctor:

Doctor's Name: _____

Address: Street: _____

City: _____ State: _____ Zip: _____

Phone _____ Fax _____

Please release the following records:

Health Records X-Ray Reports X-Rays Lab Results

Other: _____

Requested by: Dr. Nikolas R. Hedberg

Attn. Dr. _____

Patient's Signature: _____

Date Requested: _____