Hammett Functional Holistic Medicine

Please read this before beginning:

Welcome to Hammett Functional Holistic Health. We are excited you are here, and we are happy to be a part of your healthcare journey.

Before we begin, we would like to take this moment to explain the procedures of our clinic.

Hammett Functional Holistic Health is a natural, holistic healthcare clinic that focuses on healing from within. Dr. Hammett has 20 years of experience as a Doctor of Chiropractic and Functional Medicine Practitioner, she strives to balance the entire body through food, high quality supplements and lifestyle balancing techniques. When working with us, please note that we only offer services that are designed specifically with you in mind. There are no cookie-cutter approaches to care, so each suggestion is going to be tailored to your needs. After our initial discovery call, we can make specific suggestions on tests, and from that point on we will create a plan of action that fits your healthcare goals.

If you are ready to figure out the root cause of whatever is going on, let's begin! Take the time to go through this intake form. It will take at least 30 minutes, but don't worry. You can always save and come back to it if needed. We do, however, recommend going through it in one sitting if you can. Please explain everything you have experienced in as much detail as you can manage. Everything is connected! Then, jump on a call with one of our doctors to determine the best testing. We will get the necessary kits to you immediately so we can figure out what your needs are.

Once all the lab work is completed, you will come back for a report of findings visit where you will be presented with a comprehensive plan of action that includes dietary changes, supplements, and brain-balancing options.

You are in the right place, and we look forward to helping you!

Yours in Health,

Dr. J.L.Hammett, D.C., B.S.

NEW PATIENT PAPERWORK

Dear Patient,

Welcome! And thank you for choosing us as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

During your initial consultation we will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 2:

Once you have completed your lab tests, we will explain the meaning of your test results to you in a follow up consultation. We will create an individualized therapeutic program for you including diet changes, nutritional supplements, and exercise, lifestyle and stress management advice.

STEP 3:

Subsequent consultations are scheduled to monitor your progress. We will also design an ongoing wellness program to be reviewed and updated with our staff at no charge every six months.

We invite you to contact us via email or phone should you have any questions during the course of your treatment.

We look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

Yours in Health,

Dr. Jennifer Hammett, B.S.,D.C.

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize you to release my personal medical information to me.

Patient's Signature: _____ Date: _____

Name:				Date:
Address:			Country:	
City:		State:		Zip/Postal Code:
Home Phone:	Work Phone:		Fax:	
E---mail:		Cell Phone:		
Please mark your preference for occasional follow up communication from our office: ☐ Email ☐ Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:			Referred by:	
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight _____ Height _____ Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____

please list (attach sheet if necessary)

_____

2. In the past, have you used birth control pills and/or antibiotics?_____

a. For how long?_____

3. If you have fillings, please list material(s) used:_____

4. Do you presently, or have you ever had any of these conditions? (**check all that apply)**

Anemia ☐	Frequent headaches ☐	Skin condition ☐
Arthritis ☐	Heartburn ☐	Thyroid condition ☐
Asthma ☐	High blood pressure ☐	Unexplained weight change ☐
Chest pains ☐	High cholesterol ☐	Other ☐
Chronic cold/flu symptoms ☐	Hypoglycemia ☐	
Chronic fatigue ☐	Kidney problems ☐	
Depression ☐	Liver problems ☐	
Diabetes ☐	Osteoporosis ☐	

5. How much sleep do you get each night on average?_____

6. Do you have any food allergies, sensitivities or restrictions?_____

_____

7. Do you smoke, drink alcohol or use recreational drugs?_____

a. How much, how often?_____

b. How often do you drink caffeinated beverages?_____

8. Please list foods you tend to overeat or crave (sweets, breads, fatty foods, meats, milk, etc.):

_____

9. Are there foods that you eat on a daily basis, almost daily basis?_____

_____

a. Do you "miss" these foods if you do not eat them?_____

10. Write briefly about your weight gain/loss history:_____

_____

a. What do you feel triggered your weight fluctuation? (**check**) heredity ☐ stress ☐ eating habits ☐ boredom ☐

b. Was your weight gain/loss: (**check**) sudden ☐ gradual ☐ problem since childhood ☐

11. Please list close relatives that have diabetes, heart disease or obesity:_____

_____

12. What methods have you tried to lose/gain weight?_____

_____

13. How is your energy level?_____

a. Are there times in the day that you feel best?_____worst?_____

14. Are you happy in your life right now?_____

15. What are your main sources of stress_____

_____

16. How do you deal with your stress?_____

_____

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes☐ No☐

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes☐ No☐

c. I get tired and/or hungry in the mid---afternoon. Yes☐ No☐

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.
Yes☐ No ☐

e. Now and then I think I am a secret eater. Yes ☐ No☐

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes☐ No☐

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes☐ No☐

h. I experience cravings for sugar, breads, pasta and baked goods. Yes☐ No☐

i. I feel shaky if I don't eat on time or if I don't snack. Yes☐ No☐

j. I often find myself irritable or angry. Yes☐ No☐

18. Check off any of the following that have applied to you <u>within the last 30 days:</u>

☐ Do you feel nauseous?	☐ Do you have abdominal/intestinal pain?
☐ Do you have bloating?	☐ Do you get bloated after meals?
☐ Do you get heartburn?	☐ Do you have diarrhea?
☐ Do you have constipation?	☐ Do you travel outside of the U.S.?
☐ Do you have gas?	☐ Are your stools compact/hard to pass?
☐ Do you belch following meals?	☐ Do you have gurgles in your stomach?
☐ Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit☐ Below average☐ Average ☐ Above average☐ Very fit☐

25. How often do you exercise? _____

a. What is your regimen?_____

_____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

_____

27. What are your fitness goals? (check all that apply)

☐ General fitness endurance	☐ Muscle toning
☐ Weight loss/maintain weight	☐ Muscle strengthening
☐ Osteoporosis prevention	☐ Muscular coordination/balance
☐ Specific sport enhancement	Other_____
☐ Flexibility	

28. Surgeries, starting with most recent:_____

29. Hospitalizations:_____

30. Briefly describe where you have lived since childhood:_____

_____

_____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Check "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
☐ Now ☐ Past Satisfactory	☐ Now ☐ Past Feel depressed
☐ Now ☐ Past Boring	☐ Now ☐ Past Have anxiety
☐ Now ☐ Past Demanding	Do you often:
☐ Now ☐ Past Unsatisfactory	☐ Now ☐ Past Have irrational fears
Do you worry over:	☐ Now ☐ Past Feel upset
☐ Now ☐ Past Home life	☐ Now ☐ Past Feel things go wrong
☐ Now ☐ Past Marriage	☐ Now ☐ Past Feel shy
☐ Now ☐ Past Children	☐ Now ☐ Past Cry
☐ Now ☐ Past Job	☐ Now ☐ Past Feel inferior
☐ Now ☐ Past Income	Have you:
☐ Now ☐ Past Money problems	☐ Now ☐ Past Seriously considered suicide
	☐ Now ☐ Past Attempted suicide

POLICIES AND PROCEDURES

(please retain for your records)

New Patients:

First Appointment

Your first consultation will be 45 minutes – 1 hour. During this time we will determine the appropriate lab tests you should order to address your specific health concerns.

1. Payment is due at time of consultation
2. Methods of payment are: Check or money order (in advance) Visa, MasterCard or American Express.
3. All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

Appointments:

- Follow---up consults may be scheduled in 15, 30, 45, or 60---minute blocks of time.
- We encourage you to book your appointments 2 weeks in advance.
- As a courtesy to you, our office will call you to confirm your appointment one day in advance. You may also receive a reminder via email.

Lab Tests:

- The results of your lab test(s) will be sent to us 2 to 4 weeks after mailing your specimens to the lab.
- We will evaluate the results. After evaluation you will be contacted to schedule a follow---up appointment.

Cancellations:

- If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you may be charged for that appointment.

Returned Products:

- PRE---APPROVAL is REQUIRED on ALL RETURNS!!
- Refrigerated items CANNOT be returned
- 15% restock fee of purchase price less shipping and handling may be refunded on unopened and non---refrigerated items
- No supplement returns will be accepted after 30 days on all regularly stocked items. Special

orders CANNOT be returned!

- Prepaid tests can be returned for credit within one year of purchase.

Important Notes:

- We do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- Please contact the office if you are not clear on any of our policies or procedures.

I_____have read and understood the Policies and Procedures. (please print name)

Date_____

Signature_____

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: _____

Address: _____

I, _____ request the following information:

☐ Test results ☐ History ☐ Records ☐ Diagnosis

☐ Treatment ☐ Reports ☐ Progress

Concerning my: ☐ Accident ☐ Injury ☐ Illness

Other _____

To be released to: _____

(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of: _____

(Specify)

According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.

Signed: _____ Date: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

Hammett Functional Health Systems

Informed Consent for Telemedicine Services

PATIENT NAME: _____	DATE OF BIRTH:	MEDICAL RECORD #:
LOCATION OF PATIENT: _____	_____	_____

PHYSICIAN NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____ CONSULTANT NAME: _____ LOCATION: _____	DATE CONSENT DISCUSSED: _____

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include good faith measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improving access to medical care by enabling a patient to remain in his/her home (or at a remote site) to receive necessary medical care.
- Enabling the physician to obtain test results and consult with other healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any healthcare procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate health professional decision making by the physician and consultant(s);
- Delays in healthcare evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal healthcare information;
- In rare cases, a lack of access to complete healthcare records may result in adverse drug interactions or allergic reactions or other judgment errors;
- In rare cases, patients who withhold key healthcare or medical history or provide incomplete medical history may receive medical care that is not relevant or contraindicated, thereby putting the patient at risk for an adverse reaction to the healthcare treatment rendered
- Failure to follow the instructions and recommendations of the remote practitioner could result in an adverse reaction to the healthcare treatment rendered.

Please initial after reading this page: _____

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical and/or other healthcare information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of healthcare may be available to me, and that I may choose one or more of these at any time. My healthcare practitioner has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical and/or healthcare information to other healthcare practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my healthcare practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my healthcare.

I hereby authorize _____ ***(name of provider)*** to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient:

_____

*Witness:*_____ *Date:* _____

I have been offered a copy of this consent form (patient's initials) _____

Hammett Functional Health Systems

www.drhammett.com

ADULT TOXIN EXPOSURE QUESTIONNAIRE

If you have been exposed to any of these in the LAST 12 MONTHS please check:

- **(Y)** Yes
- **(N)** No
- **(?)** Unknown
- **(P)** for exposure more than 12 months ago

Community

Do you have regular exposure to:	Y	N	?	P	Notes
Automobile exhaust	☐	☐	☐	☐	
Farm/Industrial/Power plant or lines	☐	☐	☐	☐	
Radio tower	☐	☐	☐	☐	
Landfill/Dump	☐	☐	☐	☐	
Hydro tower	☐	☐	☐	☐	

Home and/or Work Environment

Do you live in a: (Check one)	☐ House	☐ Apartment Building	Mobile Home ☐
Do you work in a: (Check one)	☐ House	☐ Office Building	Factory ☐
Bathing/Showering water source: (Check one)	☐ Well	☐ Public Works	Bottled ☐

Do you have regular exposure at home or work to:	Y	N	?	P	Notes
Forced air heat	☐	☐	☐	☐	
Renovations (new carpets; add ons; etc…)	☐	☐	☐	☐	
Basement cracks or dirt floor	☐	☐	☐	☐	
Damp basement or crawl space	☐	☐	☐	☐	
Wet windows or outside closet walls	☐	☐	☐	☐	
Water leaks (ceilings, walls, floors)	☐	☐	☐	☐	
Visible mold	☐	☐	☐	☐	
Old or cracking ceiling tiles	☐	☐	☐	☐	
Old or cracking vinyl linoleum flooring	☐	☐	☐	☐	
Crumbling pipe insulation	☐	☐	☐	☐	
Crumbling wall or ceiling insulation	☐	☐	☐	☐	
Old or cracking paint	☐	☐	☐	☐	

	Y	N	?	P
Carpets or rugs				
Stagnant or stuffy air				
Gas or propane stove				
Coal or wood stove				
Other gas appliance (water heater, furnace)				
Regular contact with smokers				

Do you have regular exposure to:	Y	N	?	P	Notes
Pesticides or herbicides					
Harsh chemicals (varnish, glue, gas, acid…)					
Welding or soldering					
Metals (Lead, Mercury, etc)					
Paints					
Photo developing / Dark room					
Airplane travel					
Cleaning chemicals					

Personal-Diet

Drinking/Cooking water source:	Well	Public Works	Bottled	Filtered
Caffeine?	What kind:	How Much:		

Do you regularly eat:	Y	N	?	P	Notes
Fish (fresh, frozen, canned, etc.)					
Artificial sweeteners (Specify in notes): NutraSweet, Equal, Aspartame, Splenda					
Alcohol					
Animal products					
• How often?					
• What percentage of your animal product is organic?					
Do you wash your produce					
• What percentage of your produce is organic?					
Deep fat fried foods					
Sodas, juices, drinks containing High Fructose Corn Syrup – how many per day?					

Do you have:	Y	N	?	P
Allergies	☐	☐	☐	☐
Sensitivity to smells (gas, perfume, paint, etc…)	☐	☐	☐	☐
Artificial materials in the body (implants, pins, joints, etc…)	☐	☐	☐	☐
Immunizations	☐	☐	☐	☐
Have you ever:	**Y**	**N**	**?**	
Used tobacco	☐	☐	☐	☐
Experimented with recreational drugs	☐	☐	☐	☐
Led a high stress lifestyle	☐	☐	☐	☐
Experienced a stressful or traumatic event	☐	☐	☐	☐
Been under anesthesia	☐	☐	☐	☐
Had an illness during foreign travel	☐	☐	☐	☐
Had an illness while camping or hiking	☐	☐	☐	☐
Had food poisoning	☐	☐	☐	☐

Dental

Dental

	Y	N	?	Notes
Do you currently have amalgam fillings or caps?	☐	☐	☐	
• How many amalgam fillings do you have now?				
Have you removed or lost dental fillings or caps?	☐	☐	☐	
Did you have fillings as a child?	☐	☐	☐	
• How many fillings did you have?				
Did you have your Wisdom teeth removed?	☐	☐	☐	
• At what age?				
• Any complications such as dry socket or abscesses?				
Do you have any root canal treated teeth?	☐	☐	☐	
• How many and when were they placed?				
Did your mother have dental fillings prior to giving birth to you?	☐	☐	☐	
• During her pregnancy with you?	☐	☐	☐	
Other:				

Please list all **PRESCRIPTION** or **OVER THE COUNTER** medications you currently take on a regular basis, including birth control pills and allergy injections:

Name of medication	Dose (mg, ML, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Please list all **VITAMINS/MINERALS**, **HERBS**, or **OTHER SUPPLEMENTS** you currently take on a regular basis:

Name of supplement	Dose (mg, ML, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

Drug Adverse Reactions: Please list ANY medication / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:

Name of medication/ immunization	Type of side effects or allergic reaction that caused you to stop it	Age	Year

FOOD SENSITIVITY INTAKE FORM

Hammett Functional Health Systmes

Phone: 510-779-2772 Fax: 510-338-9747

Welcome To Our Office. Please Fill Out The Following Information Thoroughly So The Doctor Can Let You Know If You Are A Case We Can Accept. Please Feel Free To Ask Any Questions If You Need Assistance. We Look Forward To Serving You!

Name: _____ Date:_____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Birth Date: _____ Marital Status S M D W

How Were You Referred To This Office: _____

Are you in good health at the present time to the best of your knowledge? ☐ Yes No ☐

Are you under a doctor's medical supervision at this time? ☐ Yes No ☐
If yes, for what? _____

Are you taking any medications at the present time? ☐ Yes No ☐
If yes, what medications? _____
_____

History of high blood pressure? ☐ Yes No ☐

History of diabetes? ☐ Yes No ☐

History of frequent headaches or migraines? ☐ Yes No ☐
If yes, how often? _____ Medication? _____

History of constipation? ☐ Yes No ☐

Serious injuries? ☐ Yes No ☐
Details: _____

Surgeries? ☐ Yes No ☐
Details:_____

Do weight problems run in your family? Yes No
If Yes, who? _____

Do you have a family history of:

- Diabetes? If Yes, who? _____
- Heart Disease? If Yes, who? _____
- Cancer? If Yes, who? _____
- Stroke? If Yes, who? _____

Nutritional Evaluation:

Present Weight: _____ Height: _____ Desired Weight:_____

When would you like to be at your desired weight?

Why do you want to lose weight? (Health Benefit? Appearance?) Please explain thoroughly:

_____

_____

When did you begin gaining weight? _____
Reason why? _____

What has been your maximum weight (non-pregnant) and when? _____

Have you tried other weight loss program? Yes No
If yes, which ones? _____

Were you successful with it / were you able to keep the weight off? Yes No
Please explain: _____

Is your spouse, fiancée or partner overweight? Yes No
By how much is he/she overweight? _____

How often do you eat out? _____

What restaurants do you frequent? _____

How often do you eat "fast foods"? _____

Food allergies:_____

Food dislikes:_____

Food cravings:_____

Do you drink coffee or tea? Yes No If yes, how much daily? _____

Do you drink pop / soft drinks? Yes No If yes, how much daily? _____

Do you drink alcohol? ☐ Yes ☐ No
What? _____ How much? _____ Weekly? _____

Do you use sugar substitutes? ☐ Yes ☐ No
If yes, what? _____

What are your worst food habits? _____
_____

Snack habits:
What:_____
How Much:_____
When:_____

When there is increased stress in your life, do you tend to eat more? ☐ Yes ☐ No
Explain:_____

Do you smoke? ☐ Yes ☐ No
If yes, how much? _____

Typical Breakfast:
What: _____
When:_____

Typical Lunch:
What:_____
When:_____

Typical Dinner:
What:_____
When:_____

Describe your energy level? _____

Activity level: (check one)
☐ Inactive
☐ Light activity
☐ Moderate activity
☐ Heavy activity
☐ Vigorous activity

On a scale of 1 to 10 with 10 being **MOST** committed, how committed are you to taking action and making a change in your life today? 1 2 3 4 5 6 7 8 9 10

_____ _____
Patient Signature: Date: