Thrive Functional Wellness Center

Steps for your appointment:

1) Please fill out all New Patient forms in their entirety.

2) Please fax, scan or drop off your completed paperwork and bloodwork **2-3 days before your scheduled consultation.**

3) If you are married or in a relationship, **please bring your spouse or significant other** with you to your appointment.
   (*There will be much information covered concerning your unique condition as well as the fundamentals of the program.)*

4) Please arrive on time.

5) We require a 24-hour notice to change or cancel your appointment.

Note: *If these steps are not followed it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.*

Thank you and we look forward to seeing you at our office.

Dr. Grey A Rappe, DC

Certified Functional Medicine Practitioner

78474 Hwy 111 Suite C

La Quinta, CA 92253

760-777-4177

760-777-4174 (fax)

Email paperwork and bloodwork: lorrie.rappe@thrivefunctionalwellness.com

www.thrivefunctionalwellness.com

Thrive Functional Wellness Center
Dr. Grey A. Rappe, DC

78474 Hwy 111 Suite C
La Quinta, CA 92253
760-777-4177

Patient Introduction

Personal History:

Your Name: ____
First Middle Last

Your Address:

____
Street City/State Zip

Telephone: Home:______________________ Bus: _________________

Email Address: ____

Birth Date: Month: __________ Day: ____________ Year: __________

Marital Status:____________Occupation: _________________________

Employer: ____

Other family members: Parents: ____________________________________

Siblings names and ages: ____

Do you live here full time? **Yes or No** If **no**, date you are leaving: ____________

Present MD: _______________________________ City: ____________

Referred to our Center or Seminar by:
____

Thank You!

Thrive Functional Wellness Center

Initial Consultation

Name: ______________________________________ Date: ________________________

Main Complaints:

1)__________________________________ 2)___________________________________

3)__________________________________ 4)___________________________________

How long have you suffered with this problem? __________________________________

Any other complaints: ____

____

Would you like improvement with any of the following?:

- ☐ Digestion: Reflux, Gas, Constipation
- ☐ Sleep: Falling asleep or staying asleep
- ☐ Sense of Well Being
- ☐ Energy
- ☐ School performance
- ☐ Concentration & Focus
- ☐ Weight
- ☐ Relationships

What have you tried doing to resolve this problem that <u>Did Not</u> work?

____

____

Have you become discouraged or stressed about handling this problem?

____

____

When your problem is at its worst, how does it make you feel?

____

How does this problem interfere with the following areas in your life?
School: ____
Work: ____
Family: ____
Hobbies: ____
Life: ____

When it's at its worst, how much older does this make you feel? ____________________

Do you know how this problem may have started? ________________________________

____

What effect does this have on your body functions? ______________________________

____

Are you here visiting us to:
a) Resolve my immediate problem
b) Life style program for optimized living
c) Both
d) Other: ____

How have you taken care of your health in the past?

Medications	Holistic
Routine medical	Vitamins
Exercise	Chiropractic
Diet & Nutrition	Other: ____________________________

How did the previous methods work for you? ________________________________

____

What are you afraid this might be or will be affecting without change? Please circle:

Jobs	Relationships	School Performance
Kids	Family	Future abilities
Marriage	Freedom	Finances
Sleep	Travel	Time

Are there any health conditions you are afraid this might turn into?

Diminished Future Abilities	Surgery	Dementia
High Blood Pressure	Arthritis	Alzheimers
Weight Gain	Cancer	Stress
Heart Disease	Diabetes	Liver Disease
Depression	Other: __________	

Where do you picture yourself in the next 3-5 years if you don't take ACTION to address these issues? Please be specific: ______________________________________

____

____

What would be different or better without this problem? Please circle:

Diminished Stress	Sleep	School Performance
More Energy	Work	Testing Outcomes
Self esteem	Outlook	Positive Mindset
Confidence	Family	Relationships

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

____
____
____
____
____

What potential barriers do you foresee that would prevent these things from happening?
____
____
____

Do you feel it is possible to eliminate or prevent these potential barriers?

____
____
____

What are your strengths that will enable you to accomplish your goals?
____
____
____

Rate on a scale of 1-10:
________ How important is it for you to resolve your health concerns?
________ Do you feel that you are coachable and would enjoy a mentor in helping you?
________ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Please list all medications you are currently taking:

Name: Reason for taking:

____

____

____

____

____

____

____

____

____

____

____

____

Please list all vitamins and supplements you are currently taking:

____

____

____

____

____

____

____

Thank You!

Metabolic Assessment Form™

Name: ____ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

Please list your 5 major health concerns in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

© 2013 Datis Kharrazian. All Rights Reserved.
SMGHMAF04(062513)

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*				
How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ________________ ________________ ________________

List the three healthiest foods you eat during the average week: ________________ ________________ ________________

PART IV

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____

© [illegible] All Rights Reserved.
[illegible]

Family Health History

Patient Name: ______________________________ Date: _________________

Please review the conditions listed below and indicate those that are current health problems of a family member by designation **C** under his or her column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children	Children	Children
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Colitis						
Constipation						
Depression						
Diabetes						
Disc Problems						
Ear Infections						
Emotional Issues						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney Trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scollosis						
Sinus Trouble						
Other:						