Julian Healthcare
Application Questionnaire

General lnformation:

Today's Date:_____

Name:_____ Age:_____

Date of Birth:_____ Email: _____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

When, Where and from Whom Did You Last Receive Medical or

Healthcare?: _____

_____

Emergency Contact:_____ Relationship:_____

Phone:_____

Do you Have Medicaid, HIP or State-Funded MDWISE lnsurance?: YES/NO

How Did You Hear About Our Practice:

❑ Clinic Website ❑ IFM Website ❑ Referral from Family/Friend

❑ Social Media ❑ Other:_____

What Are Your Health Goals?:

_____

_____

_____

_____

Current Health Concerns: Treatment for This:

Medications/Supplements Taking:

Medical History: Illnesses/Conditions

Check YES= a condition you currently have, **Check PAST**= a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	❑	❑
GERD (reflux)	❑	❑
Crohn's disease/ulcerative colitis	❑	❑
Peptic ulcer disease	❑	❑
Celiac disease	❑	❑
Gallstones	❑	❑
Other:	❑	❑
Respiratory		
Bronchitis	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
Pneumonia	❑	❑
Sinusitis	❑	❑
Sleep apnea	❑	❑
Other:	❑	❑
Urinary/Genital		
Kidney stones	❑	❑
Gout	❑	❑
Interstitial cystitis	❑	❑
Frequent yeast infections	❑	❑
Frequent urinary tract infections	❑	❑
Sexual dysfunction	❑	❑
Sexually transmitted diseases	❑	❑
Other:	❑	❑
Endocrine/Metabolic		
Diabetes	❑	❑
Hypothyroidism (low thyroid)	❑	❑
Hyperthyroidism (overactive thyroid)	❑	❑
Polycystic Ovarian Syndrome	❑	❑
Infertility	❑	❑
Metabolic syndrome/Insulin resistance	❑	❑
Eating disorder	❑	❑
Hypoglycemia	❑	❑
Other:	❑	❑
Inflammatory/Immune		
Rheumatoid arthritis	❑	❑
Chronic fatigue syndrome	❑	❑
Food allergies	❑	❑
Environmental allergies	❑	❑
Multiple chemical sensitivities	❑	❑
Autoimmune disease	❑	❑
Immune deficiency	❑	❑
Mononucleosis	❑	❑
Hepatitis	❑	❑
Other:	❑	❑

Musculoskeletal	Yes	Past
Fibromyalgia	❑	❑
Osteoarthritis	❑	❑
Chronic pain	❑	❑
Other:	❑	❑
Skin		
Eczema	❑	❑
Psoriasis	❑	❑
Acne	❑	❑
Skin Cancer	❑	❑
Other:	❑	❑
Cardiovascular		
Angina	❑	❑
Heart attack	❑	❑
Heart failure	❑	❑
Hypertension (high blood pressure)	❑	❑
Stroke	❑	❑
High blood fats (cholesterol, triglycerides)	❑	❑
Rheumatic fever	❑	❑
Arrythmia (irregular heart rate)	❑	❑
Murmur	❑	❑
Mitral valve prolapse	❑	❑
Other:	❑	❑
Neurologic/Emotional		
Epilepsy/Seizures	❑	❑
ADD/ADHD	❑	❑
Headaches	❑	❑
Migraines	❑	❑
Depression	❑	❑
Anxiety	❑	❑
Autism	❑	❑
Multiple sclerosis	❑	❑
Parkinson's disease	❑	❑
Dementia	❑	❑
Other:	❑	❑
Cancer		
Lung	❑	❑
Breast	❑	❑
Colon	❑	❑
Ovarian	❑	❑
Skin	❑	❑
Other:	❑	❑

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Take several nutritional supplements each day	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Keep a record of everything you eat each day	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Modify your lifestyle (e.g., work demands, sleep habits)	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Practice a relaxation technique	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Engage in regular exercise	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

Comments _____

_____

Cancellation/No Show Policy

Our office understands that there are times when you must miss an appointment due to other obligations. However, when you do not call to cancel a scheduled appointment, you may be preventing another patient from getting the treatment they are needing. If you have three no show appointments, we will have to dismiss you from our practice.

If an appointment is not cancelled at least 24 hours in advance, you will be charged an office fee.

_____
Print Patient Name

_____ _____
Signature of patient/guardian Date