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IMAGINE WELLNESS FUNCTIONAL MEDICINE
CENTRE OF SAN ANTONIO
115 GALLERY CIRCLE STE. 209
SAN ANTONIO, TX. 78258
210.798.9322

Personal History

Your Name: _____
First Middle Last

Your Address: _____
Street City/State Zip

Telephone: Home:_____ Cell:_____

Email Address: _____

Birth Date: _____ Social Security Number: _____

Marital Status:_____ Occupation:_____

Employer:_____ Present MD:_____

Areas of Interest:
- ☐ Wellness Programs
- ☐ Food Allergy Testing
- ☐ Hormone Therapy
- ☐ Detox
- ☐ Weight Loss
- ☐ Disease Prevention
- ☐ Testing
- Other: _____

Main Complaints and How long have you suffered these problems?

1) _____ _____ 2) _____ _____
3) _____ _____ 4) _____ _____
5) _____ _____ 6) _____ _____
7) _____ _____ 8) _____ _____

Referred to our Centre or Seminar by: _____

Medications:

1) _____ Condition:_____
2) _____ Condition:_____
3) _____ Condition:_____
4) _____ Condition:_____
5) _____ Condition:_____
6) _____ Condition:_____
7) _____ Condition:_____
8) _____ Condition:_____
9) _____ Condition:_____
10) _____ Condition:_____

Thyroid Patients Only:
How Long did you have symptoms prior to being diagnosed?_____
If on thyroid medication, how long have you been on? _____
Has your medications been adjusted frequently? Y ☐ N ☐
Do you have any symptoms of brain fog or memory difficulties? Y ☐ N ☐
Do you have joint inflammation? Y ☐ N ☐
Do you consume grains? Y ☐ N ☐ Do these foods irritate your bowels? Y ☐ N ☐
Do you have heart palpitations? Y ☐ N ☐ Do you have hot flashes or sweat attacks? Y ☐ N ☐
Have you been diagnosed with an autoimmune condition? Y☐ N ☐
If Yes, what condition? _____

Please list any allergies to foods, dyes or other substances and type of reaction:
_____
_____

Would you like improvement with any of the following?

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that Did Not work?

_____

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

Do you know how this problem may have started? _____
_____

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

❑ Medications ❑ Holistic ❑ Routine medical
❑ Vitamins ❑ Exercise ❑ Chiropractic
❑ Diet and Nutrition ❑ Other: _____

How did the previous methods work for you? _____
_____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific _____
_____

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

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?

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Metabolic Assessment Form Key

Please circle the appropriate number 0-3 on all questions below (0 as the least/never to 3 as the most/always)

Category I: Colon

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relief 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 of "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
Do you use laxatives frequently? 0 1 2 3

Category II: Hypochlorydia

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; 0 1 2 3
undigested foods found in stools 0 1 2 3

Category III: Hyperacidity (Ulcer)

Stomach pain, burning or arching 1-4 hrs after eating 0 1 2 3
Do you frequently use antacids? 0 1 2 3
Feeling hungry an hour or two after eating 0 1 2 3
Heartburn when lying down bending forward 0 1 2 3
Temporary relief from antacids, food, milk, 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 IV: Small Intestine (Pancreas)

Roughage and fiber cause constipation 0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating 0 1 2 3
Pain, tenderness, soreness on left side under rib cage bloated 0 1 2 3
Excessive passage of gas 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
Difficulty losing weight 0 1 2 3

Category V: Biliary Insufficiency/ Statis

Greasy or high fat foods cause distress 0 1 2 3
Lower bowel gas and or bloating several hrs after eating 0 1 2 3
Bitter metallic taste in mouth, especially in the morning 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 VI: Hypoglycemia

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep yourself going or started 0 1 2 3
Get lightheaded if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, 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 VII: Insulin Resistance

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 & appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

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Category VIII: Adrenal Hypofunction

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 IX: Adrenal Hyperfunction

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

Category X: Hypothyroid

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 gain 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 falling hair	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XI: Thyroid Hyperfunction

Heart palpations	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
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XII: Pituitary Hypofunction

Diminished sex drive	0 1 2 3
Menstrual disorders or lack of menstruation	0 1 2 3
Increased ability to eat sugars without Symptoms	0 1 2 3

Category XIII: Pituitary Hyperfunction

Increased sex drive	0 1 2 3
Tolerance to sugar reduced	0 1 2 3
"Splitting" type headaches	0 1 2 3

Category XIV (Males Only): Prostate

Urination difficulty or dribbling	0 1 2 3
Urination frequent	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel evacuation	0 1 2 3
Leg nervousness at night	0 1 2 3

Category XV (Males Only): Andropause

Decrease in libido	0 1 2 3
Decrease in spontaneous morning erections	0 1 2 3
Decrease in fullness of erections	0 1 2 3
Difficulty in maintain 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
Decrease in 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 XVI (Menstruating Females only):

Are you premenopausal?	Yes No
Alternating menstrual cycle lengths	Yes No
Extended menstrual cycle, greater than 32 days	Yes No
Shortened menses, less than every 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 break outs	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

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Category XVII (Menopausal Females only):

How many years have you been menopausal?_____

Do you ever have uterine bleeding since menopause? 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

Foods: How many:

alcohol beverages do you consume per week? _____

caffeinated beverages do you consume per day? _____

times do you eat out per week? _____

times a week do you eat fish? _____

times a week do you workout? _____

Do you smoke? Y ☐ N ☐

If Yes, how many times _____ day_____wk

Rate your stress levels on a scale of 1-10 during the average week _____

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Family Health History

Please review the conditions listed below. Write "C" under their column to indicate health problems are current and write "P" to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	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 press.						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

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Acknowledgement of Receipt of Notice of Privacy Practice

I, _____ have received a copy of Dr. Jimenez

Wellness Notice of Privacy Practice _____
(Signature of Patient or Guardian)

Section to be filled out by staff if patient's signature not obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

☐ Patient refused to sign
☐ Emergency situation kept us from obtaining the patient's signature
☐ Language barriers kept us from obtaining the patient's signature
☐ Other: _____

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Directions

From US highway 281 & Loop 1604: Travel west on 1604 to Stone Oak Pkwy and turn right. Head north about a ¼ mile to Gallery Circle and turn right. Follow it back to the end of the cul-de-sac and park anywhere around the building or in the cul-de-sac.

From IH10 & Loop 1604: Travel east on 1604 to Stone Oak Pkwy and turn left. Head north about a ¼ mile to Gallery Circle and turn right. Follow it back to the end of the cul-de-sac and park anywhere around the building or in the cul-de-sac.

From Huebner & Stone Oak Pkwy: Travel south on Stone Oak Pkwy, past Sonterra Blvd. and turn left on Gallery Circle. Follow it back to the end of the cul-de-sac and park anywhere around the building or in the cul-de-sac.