Dr. Noah Edvalson, DC, NMD, CCSP, FIAMA, FAAO
3224 N. Maple Grove Rd. Boise, ID 83704
(208) 629-5374
www.theICIM.com

Functional Health Assessment Form

Name: _____ Age: _____ Sex: ____ Date: _____

Occupation: _____ TOTAL FHA SCORE_____

PART I:

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

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any conditions you have been previously diagnosed with by another physician:

1. _____Date_____
2. _____Date_____
3. _____Date_____
4. _____ Date _____
5. _____Date_____

Please list ALL surgeries you've had in your life (include C-sections, Cosmetic, Hernias, Dental, etc...):

1. _____Reason_____ Mo/Yr_____
2. _____Reason_____ Mo/Yr_____
3. _____Reason_____ Mo/Yr_____
4. _____Reason_____ Mo/Yr_____
5. _____Reason_____ Mo/Yr_____

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

1. _____Condition_____
2. _____Condition_____
3. _____Condition_____
4. _____Condition_____
5. _____Condition_____
6. _____Condition_____
7. _____Condition_____

Please list any significant results of any lab, x-ray, MRI, CT, or other recent studies:

1. _____Date_____
2. _____Date_____
3. _____Date_____
4. _____Date_____
5. _____Date_____

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

1. _____Condition_____
2. _____Condition_____
3. _____Condition_____
4. _____Condition_____
5. _____Condition_____
6. _____Condition_____

PART II:

Please choose the appropriate number "0 - 4" on all questions below.

0 = the least/never 4 = the most/always.

Category I	Least/Never	0	1	2	3	4	Most/Always
Feeling that bowels do not empty completely							
Lower abdominal pain relieved by passing stool or gas							
Diarrhea (loose stool, not formed)							
Constipation (strain to have BM, or small/hard pieces)							
Hard, dry, or small stool							
Coated tongue or "fuzzy" debris on tongue							
Pass large amount of foul smelling gas							
More than 3 bowel movements daily							
Use laxatives frequently							
	TOTAL SCORE						

Category II	Least/Never	0	1	2	3	4	Most/Always
Excessive belching, burping, or bloating							
Gas immediately following a meal							
Offensive breath							
Difficult bowel movements							
Sense of fullness during and after meals							
Difficulty digesting fruits and veggies; undigested foods in stools							
	TOTAL SCORE						

Category III	Least/Never	0	1	2	3	4	Most/Always
Stomach pain, burning, or aching 1- 4 hours after eating							
Use of antacids							
Feeling hungry an hour or two after eating							

Heartburn when lying down or bending forward						
Temporary relief from heartburn with antacids, food, milk, carbonated beverages						
Digestive problems subside with rest and relaxation						
Heartburn w/ spicy, chocolate, citrus, peppers, alcohol, or caffeine						
TOTAL SCORE						

Category IV	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Roughage and fiber cause constipation							
Indigestion and fullness lasts 2-4 hours after eating							
Pain, tenderness, soreness on left side under rib cage							
Excessive passage of gas							
Nausea and/or vomiting							
Stool undigested, foul smelling, mucous, greasy, or poorly formed							
Frequent urination							
Increased thirst and appetite							
Difficulty losing weight							
TOTAL SCORE							

Category V	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Greasy or high fat foods cause symptoms							
Lower bowel gas and or bloating several hours after eating							
Bitter metallic taste in mouth, especially in the morning							
Unexplained itchy skin							
Yellowish cast to eyes							
Stool color alternates from clay colored to normal brown							
Reddened skin, especially palms							
Dry or flaky skin and/or hair							
History of gallbladder attacks or stones							
TOTAL SCORE							

Have you had your gallbladder removed? **Yes** ___ **No** ___

Category VI	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Crave sweets during the day							
Irritable if meals are missed							
Depend on caffeine to keep yourself going or started							
Get lightheaded if meals are missed							
Eating relieves fatigue							
Feel shaky, jittery, tremors							
Agitated, easily upset, nervous							
Poor memory, forgetful							
Blurred vision							
TOTAL SCORE							

Category VII	Least/Never	0	1	2	3	4	Most/Always
Fatigue after meals							
Crave sweets during the day							
Eating sweets does not relieve cravings for sugar							
Must have sweets after meals							
Waist girth is equal or larger than hip girth							
Frequent urination							
Increased thirst & appetite							
Difficulty losing weight							
TOTAL SCORE							

Category VIII	Least/Never	0	1	2	3	4	Most/Always
Cannot stay asleep							
Crave salt & sugar							
Slow starter in the morning							
Afternoon fatigue							
Weak immune system (susceptible to cold/flu)							
Dizziness when standing up quickly							
Afternoon headaches							
Headaches with exertion or stress							
Weak nails							
TOTAL SCORE							

Category IX	Least/Never	0	1	2	3	4	Most/Always
Cannot fall asleep							
Perspire easily							
Under high amounts of stress							
Weight gain when under stress							
Wake up tired even after 6 or more hours of sleep							
Excessive perspiration with little to no activity or exercise							
TOTAL SCORE							

Category X	Least/Never	0	1	2	3	4	Most/Always
Tired, sluggish							
Feel cold – hands, feet, all over							
Require excessive amounts of sleep to function properly							
Increase in weight gain even with low-calorie diet							
Gain weight easily							
Difficult, infrequent bowel movements							
Depression, lack of motivation							
Morning headaches that wear off as the day progresses							
Outer third of eyebrow thins							
Thinning of hair on scalp, face or genitals or excessive falling hair							
Dryness of skin and/or scalp							
Mental sluggishness							
TOTAL SCORE							

Category XI	Least/Never	0	1	2	3	4	Most/Always
Heart palpitations							
Inward trembling							
Increased pulse even at rest							
Nervous and emotional							
Insomnia							
Night sweats							
Difficulty gaining weight							
	TOTAL SCORE						

Category XII	Least/Never	0	1	2	3	4	Most/Always
Urination difficulty or dribbling							
Urination frequent							
Pain inside of legs or heels							
Feeling of incomplete bowel evacuation							
Leg nervousness at night							
	TOTAL SCORE						

MALES ONLY - Category XIII	Least/Never	0	1	2	3	4	Most/Always
Decrease in libido							
Decrease in spontaneous morning erections							
Decrease in fullness of erections							
Difficulty in maintain morning erections							
Spells of mental fatigue							
Inability to concentrate							
Episodes of depression							
Muscle soreness							
Decrease in physical stamina							
Unexplained weight gain							
Increase in fat distribution around chest and hips							
Sweating attacks							
More emotional than in the past							
	TOTAL SCORE						

Menstruating Females ONLY - Category XIV	Least/Never	0	1	2	3	4	Most/Always
Pain and cramping during periods							
Scanty blood flow							
Heavy blood flow (1+ hygiene product ea. 1-2 hrs)							
Breast pain and swelling during menses							
Pelvic pain during menses							
Anxiety/depression/mood swings around period							
Acne break outs							
Facial hair growth							
Hair loss/thinning							
Extended menstrual cycle (greater than 32 days)							
Shortened menses (less than every 24 days)							
	TOTAL SCORE						

Post Menopausal Women ONLY - Category XV	Least/Never	0	1	2	3	4	Most/Always
Hot flashes							
Mental fogginess							
Disinterest in sex							
Mood swings							
Depression							
Painful intercourse							
Shrinking breasts							
Facial hair growth							
Acne							
Increased vaginal pain, dryness or itching							
	TOTAL SCORE						

How many years have you been menopausal ___

Since menopause, do you ever have uterine bleeding **Yes** ___ **No** ___

Are you having alternating menstrual cycle lengths? **Yes** ___ **No** ___

<u>PART III</u>: Neurotransmitter Assessment

Section Brain	Least/Never	0	1	2	3	4	Most/Always
Is your memory noticeably declining							
Are you having a hard time remembering names or phone numbers							
Is your ability to focus noticeably declining							
Has it become harder for you to learn things							
How often do you forget about your appointments							
Is your temperament getting worse in general							
Are you losing your attention span endurance							
How often do you find yourself down or sad							
How often do you fatigue when driving compared to the past							
How often do you fatigue when reading compared to the past							
How often do you walk into rooms and forget why							
How often do you pick up your cell phone and forget why							
	TOTAL SCORE						

Section S	Least/Never	0	1	2	3	4	Most/Always
Are you losing your pleasure in hobbies and interests							
How often do you feel overwhelmed with ideas to manage							
How often do you have feelings of inner rage (anger)							
How often do you have feelings of paranoia							
How often do you feel sad of down for no reason							
How often do you feel like you are not enjoying life							
How often do you feel you lack artistic appreciation							
How often do you feel depressed in overcast weather							
Are you losing your enthusiasm for your favorite activities							
How much are you losing enjoyment for your favorite foods							

Are you losing your enjoyment of friendships and relationships						
How often do you have difficulty falling into deep restful sleep						
How often do you have feelings of dependency on others						
How often do you feel more susceptible to pain						
How often do you have feelings of unprovoked anger						
TOTAL SCORE						

Section D	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
How often do you have feelings of hopelessness							
How often do you have self-destructive thoughts							
How often do you have an inability to handle stress							
How often do you have anger and aggression while under stress							
Do you feel you are not rested even after long hours of sleep							
How often do you prefer to isolate yourself from others							
Do you have unexplained lack of concern for family and friends							
How easily are you distracted from finishing tasks							
How often do you feel the need to consume caffeine to stay alert							
How often do you feel your libido has been decreased							
How often do you lose your temper for minor reasons							
How often do you have feelings of worthlessness							
TOTAL SCORE							

Section G	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Do you feel anxious or panic for no reason							
Do you have feelings of dread or impending doom							
Do you feel knots in your stomach							
Do you have feelings of being overwhelmed for no reason							
Do you have feelings of guilt about everyday decisions							
Does your mind feel restless							
How difficult is it to turn your mind off when you want to relax							
Do you have disorganized attention							
Do you worry about the things you were not worried about before							
Do you have feelings of inner tension and inner excitability							
TOTAL SCORE							

Section ACH	**Least/Never**	**0**	**1**	**2**	**3**	**4**	**Most/Always**
Do you feel your visual memory (shapes & images) is decreased							
Do you feel your verbal memory is decreased							
Do you have memory lapses							
Has your creativity been decreased							
Has your comprehension been diminished							
Do you have difficulty calculating numbers							
Do you have difficulty recognizing objects and faces							
Do you feel like your opinion about yourself has changed							
Are you experiencing excessive urination							

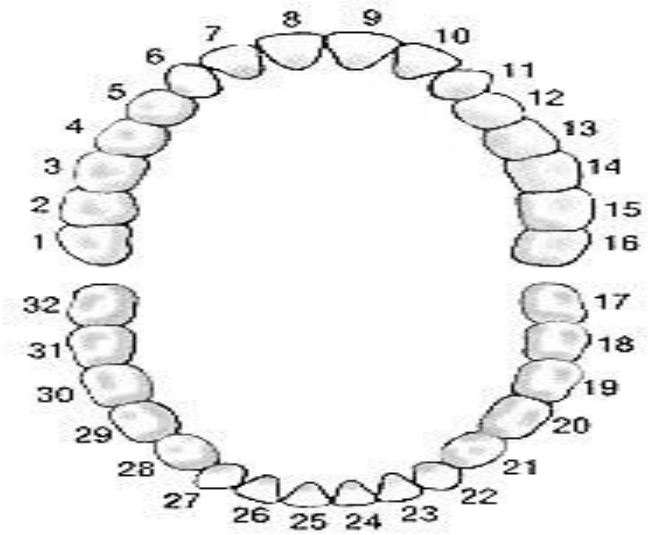
Are you experiencing slower mental response					

TOTAL SCORE

PART IV: **DENTAL**

Use the diagram below to show placement	**Y**	**N**	**?**	**Past**
Do you currently have amalgam "silver" fillings ? How Many? ____				
Have you removed or changed any dental amalgam fillings/crowns?				
Did you have amalgam fillings as a child? How Many? ____				
Do you have any **root canal** treated teeth? How Many? _____				

Please mark and label the locations of any fillings or root canals:



A = Amalgam

GC = Gold Crown
PC = Porcelain Crown
PD = Periodontal Dz
RC = Root Canal
EX = Extraction
AW= AbN Wear
I = Implant

PART V: NUTRITION

Diet:

How many servings of vegetables do you eat per day? _____
How many times per week do you workout? _____
List the three worst foods you eat during the average week: _____,
_____, _____
List the three healthiest foods you eat during the average week: _____,
_____, _____
Do you smoke?_____ If yes, how many times a day: _____
Rate your stress levels on a scale of 1-10 during the average week: _____
What is the primary source of your stress? _____

How often do you consume (per week):	**Never**	**0**	**1-3**	**4-6**	**7-10**	10+
Fish (fresh, frozen, canned, ect.)?						
Organic and pasture fed animal products?						
Organic produce?						
Artificial sweeteners: NutraSweet, Equal, Aspartame, Splenda?						

Alcohol?					
Sugary sweets (candy, ice cream, cake, donuts, etc…)					
Deep fat fried foods?					
Caffeinated beverages					
Sodas, juices, drinks containing High Fructose Corn Syrup					

PART VI: TOXIN EXPOSURE

Have you been exposed to any of these in the last 12 months?	**Y**	**N**	**?**	**Past**
Renovations (new carpets; add ons; ect.)?				
Water leaks (ceilings, walls, floors) OR Visible MOLD?				
Crumbling walls, ceiling, insulation, or paint?				
Regular contact with gas, propane, coal, or wood stove?				
Regular contact with smokers?				
Pesticides or herbicides?				
Harsh chemicals (varnish, glue, gas, acid, cleaners, etc...)?				
Welding or soldering?				
Metals (Lead, Mercury, ect.)?				
Paints?				
Photo developing / Dark room?				

PART VII: SLEEP

Have you ever been told that you snore at night?	Never	Sometimes	Often
Has it ever been reported to you that you stop breathing or gasp during sleep?	Never	Sometimes	Often
Have you ever been treated for high blood pressure?	YES		NO

Do you occasionally fall asleep during the day when:

You are busy or active?	Never	Sometimes	Often
You are driving or stopped at a light?	Never	Sometimes	Often

	What is your collar size?	**(Circle one)**
Male:	Less than 17 inches	More than 17 inches
Female:	Less than 16 inches	More than 16 inches

How motivated are you to make changes to improve your health?

1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Not very, I just want info---------->Somewhat ---------->Very, I will do anything you ask

Is there anything else about your health or history that you think is important, which we have not asked thus far?