LISA JAMES, DFM, PHD
Functional Medicine & Nutrition

WELCOME

Our mission is to help you uncover the root causes of health concerns and create a path to lasting wellness. This is done through a whole-body approach that blends advanced nutritional science with holistic care. I am here to support your journey toward optimal health—naturally and sustainably. Whether you're beginning your wellness journey or continuing it, I am honored to be a part of your path to vibrant health. I look forward to partnering with you every step.

INTAKE FORMS

PLEASE NOTE: All forms must be filled out in entirety and emailed **three (3) business days** prior to your first scheduled appointment. If forms are not received or completed and signed, you will need to forfeit your appointment and reschedule. In order to properly do an intake, I will need all information, as this benefits you in order to receive proper recommendations.

Please email completed and signed forms to:
drlisajamesphd@gmail.com

Lisa James, DFM, PhD
Doctor of Functional Health & Blood Chemistry
Certified Autoimmune Holistic Nutrition Specialist
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GENERAL INFORMATION

Name (*First, Middle Initial, Last*) _____

Date of Birth _____ Age_____

Gender: Male_____ Female_____

Marital status: □ Single □ Married □ Divorced □ Long Term Partnership □ Widow

Primary Address (*Number, Street, Apt. No.*) _____

City, State, Zip _____

Home Phone _____

Cell Phone _____

Email _____

Primary Physician Name _____

Primary Physician Phone Number _____

How did you hear about us?_____

Please list current and ongoing problems in order of priority:

Describe Problem	*Mild/ Moderate/ Severe*	*Prior Treatment/Approach*	*Any Success? Yes or No*

COMPLAINTS/CONCERNS

What do you hope to achieve in your visits with us? _____

_____

What are your goals for your health? _____

_____

_____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

Is there anything that makes you feel worse? _____

_____

Is there anything that makes you feel better? _____

_____

HOME LIFE

With whom do you live? (Include children, parents, relatives, and/or friends)

□ Spouse □ Children (how many? _____) □ Roommate(s) □ Partner □ Other _____

Do you have any pets? □ Yes □ No Do they live indoors? □ Yes □ No

Please list the types of animals you have: _____

Have you or your family experienced any major life changes? □ Yes □ No

If yes, please comment: _____

_____

Have you experienced any major losses in life? □ Yes □ No

If so, please comment: _____

_____

How important is religion (or spirituality) for you and your family? □ Not at all

□ Somewhat important

□ Extremely important

MEDICAL HISTORY **DISEASES/DIAGNOSIS/CONDITIONS** ***Please provide date of onset***

GASTROINTESTINAL

Irritable Bowel Syndrome_____
Inflammatory Bowel Disease_____
Crohn's_____
Ulcerative Colitis_____
Gastritis/Peptic Ulcer Disease_____
GERD (reflux)_____
Celiac Disease_____
Other_____

CARDIOVASCULAR

Heart Attack_____
Other Heart Disease_____
Stroke_____
Elevated Cholesterol_____
Arrhythmia (irregular heart rate)_____
Hypertension (high blood pressure)_____
Rheumatic Fever_____
Mitral Valve Prolapse_____
Other_____

METABOLIC/ENDOCRINE

Type 1 Diabetes_____
Type 2 Diabetes_____
Hypoglycemia_____
Metabolic Syndrome_____
(Insulin Resistance or Pre-Diabetes)
Hypothyroidism_____
Hyperthyroidism_____
Endocrine Problems_____
Polycystic Ovarian Syndrome (PCOS)_____
Infertility_____
Weight Gain_____
Weight Loss_____
Frequent Weight Fluctuations_____
Bulimia_____
Anorexia_____
Binge Eating Disorder_____
Night Eating Syndrome_____
Other_____

CANCER

Lung_____
Breast_____
Colon_____
Ovarian_____
Prostate_____
Skin_____
Other_____

GENITAL AND URINARY SYSTEMS

Kidney Stones_____
Gout_____
Interstitial Cystitis_____
Frequent UTIs_____
Frequent Yeast Infections_____
Erectile Dysfunction or
Sexual Dysfunction_____
Other_____

MUSCULOSKELETAL/PAIN

Osteoarthritis_____
Fibromyalgia_____
Chronic Pain_____
Other_____

INFLAMMATORY/AUTOIMMUNE

Chronic Fatigue Syndrome_____
Autoimmune Disease_____
Rheumatoid Arthritis_____
Lupus SLE_____
Immune Deficiency Disease_____
Raynaud's Disease_____
Severe Infectious Disease_____
Poor Immune Function_____
(frequent infections)
Food Allergies_____
Environmental Allergies_____
Multiple Chemical Sensitivities_____
Latex Allergy_____
Other_____

MEDICAL HISTORY – CONTINUED

RESPIRATORY DISEASES

Asthma_____
Chronic Sinusitis_____
Bronchitis_____
Emphysema_____
Pneumonia_____
Tuberculosis_____
Sleep Apnea_____
Other_____

SKIN DISEASE

Eczema_____
Psoriasis_____
Acne_____
Melanoma_____
Skin Cancer_____
Other_____

NEUROLOGICAL/MOOD

Depression_____
Anxiety_____
Bipolar Disease_____
Epilepsy_____
Headaches_____
Migraines_____
ADD/ADHD_____
Autism_____
Mild Cognitive Impairment_____
Memory Problems_____
Parkinson's Disease_____
Multiple Sclerosis_____
ALS_____
Seizures_____
Other Neurological Problems_____
_____

PREVENTIVE TESTS	**DATE**	**RESULTS/OUTCOME**
Bone Density		
Cardiac Score Test		
Cardiac Stress Test		
Carotid Ultrasound		
Colonoscopy		
CT Scan		
EKG		
Full Physical Exam		
Mammogram		
MRI		
Pap Smear		
PSA		
Thermography Scan		
Ultrasound		
Upper Endoscopy		
Upper GI Series		
Other		

SURGERIES □ None

SURGICAL PROCEDURE	DATE

HOSPITALIZATIONS □ None

DATE	REASON

ALLERGIES □ None

MEDICATION/SUPPLEMENT	REACTION

MENSTRUAL HISTORY

Age at first period: _____ Menses Frequency: _____ Length: _____

Pain: □ Yes □ No Clotting: □ Yes □ No

Has your period ever skipped? □ Yes □ No For how long?_____

Last menstrual period?_____

Do you use contraception? □ Yes □ No

If yes: □ Condom □ Diaphragm □ IUD □ Partner Vasectomy □ Other _____

□ Hormonal Contraception - Type: □ Birth Control Pills □ Patch □ Nuva Ring How long?_____

WOMEN'S DISORDERS/HORMONAL IMBALANCES

Breast Biopsy/Date:_____ □ Normal □ Abnormal_____

Last Bone Density Test:_____ □ Osteopenia □ Osteoporosis □ Within Normal Range

Are you in Menopause? □ Yes □ No Age started?_____

Do you suffer from any of the following?

□ Fibrocystic Breasts □ Endometriosis □ Fibroids □ Infertility □ PMS

□ Heavy Periods □ Hot Flashes □ Mood Swings □ Concentration/Memory Problems

□ Vaginal Dryness □ Decreased Libido □ Joint Pain □ Headaches □ Palpitations

□ Weight Gain □ Loss of Control of Urine

□ Use of Hormone Replacement Therapy? How long?_____

GI HISTORY

Have you ever had severe: □ Gastroenteritis □ Diarrhea

Do you feel like you digest your food well? □ Yes □ No

Do you feel bloated after meals? □ Yes □ No

Stool pattern - How many times a day? _____ Time of day _____

DENTAL HISTORY

Do you have any silver mercury fillings? □ Yes □ No If yes, how many?_____

Have you experienced or had any of the following?

□ Gold Fillings □ Root Canal □ Dental Implants □ Tooth Pain

□ Bleeding Gums □ Gingivitis □ Problems with Chewing

Do you floss regularly? □ Yes □ No

EXPOSURE HISTORY

Have you had a tick bite? □ Yes □ No When was (were) the tick bite(s): _____

If yes, was there a rash? □ Yes □ No

If yes, were there flu-like symptoms? □ Yes □ No

Do you live in a Lyme-endemic area? □ Yes □ No

Do you have migratory muscle pain? □ Yes □ No

Do you have migratory joint pain? □ Yes □ No

Do you have tingling/burning/numbness that migrates or comes and goes? □ Yes □ No

Have you received a prior diagnosis of chronic fatigue or fibromyalgia? □ Yes □ No

Have you received a diagnosis of a specific autoimmune disorder, such as lupus, MS, rheumatoid arthritis; or a non-specific autoimmune disorder? □ Yes □ No

Have you had a positive Lyme test in the past? □ Yes □ No How long ago? _____

MEDICATION/SUPPLEMENT QUESTIONS

Have your medication or supplements ever caused you unusual side effects or problems? □ Yes □ No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? □ Yes □ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) □ Yes □ No
Have you used antibiotics more than 3 times a year? □ Yes □ No
Have you been on any long-term antibiotics? □ Yes □ No
Have you used steroids (prednisone, nasal allergy inhalers) in the past? □ Yes □ No

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Start Date	Reason Using

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Brand Name	Dosage	Frequency	Start Date	Reason Using

FAMILY HISTORY

Please Check Family Members That Apply	Mother	Father	Brother(s)	Sister(s)	Children	Children	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other Relatives
Age (if still alive)														
Age at Death														
Cancer														
Colon Cancer														
Breast Cancer														
Ovarian Cancer														
Cervical or Uterine Cancer														
Heart Disease														
Hypertension														
Obesity														
Diabetes														
Stroke														
Osteoarthritis														
Autoimmune Arthritis (Rheumatoid, Psoriatic)														
Inflammatory Bowel Disease														
Multiple Sclerosis														
Autoimmune Diseases (Lupus, etc.)														
Irritable Bowel Syndrome														
Celiac Disease														
Asthma														
Eczema/Psoriasis														
Liver Disease														
COPD														
Dementia														
Alzheimer's														

FAMILY HISTORY (continued)

Please Check Family Members That Apply	Mother	Father	Brother(s)	Sister(s)	Children	Children	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other Relatives
Age (if still alive)														
Age at Death														
Parkinson's														
ALS or other Motor Neuron Disease														
Genetic Disorders														
Substance Abuse (such as alcoholism)														
Psychiatric Disorders														
Depression/Anxiety														
Schizophrenia														
ADHD														
Autism														
Bipolar Disease														
Allergies														
Blood Clotting Problems														
Anemia														
Hashimoto's														
Hyperthyroidism														
Hypothyroidism														
High Cholesterol														
Low Cholesterol														
Tuberculosis														
Deep Vein Thrombosis														
Sleep Apnea														
Ulcers														
Kidney Disease														
Epilepsy														
Other														

SOCIAL HISTORY/NUTRITION HISTORY

Have you ever had a nutrition consultation? □ Yes □ No If yes, how long ago? _____
Have you made any changes in your eating habits because of your health? □ Yes □ No
Describe:_____

Have you ever done and Elimination diet? □ Yes □ No
Do you currently follow a special diet or nutritional program? □ Yes □ No

Check all that apply: □ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium
□ Diabetic □ No Dairy □ No Wheat □ Gluten Restricted
□ Vegetarian □ Vegan □ Paleo Diet □ Keto Diet
□ AIP (Autoimmune Protocol) Diet □ Mediterranean Diet □ Other_____
□ Specific Program for Weight Loss/Maintenance Type: _____

Highest Adult Weight_____ Lowest Adult Weight_____ Desired Weight Range_____
Does your weight fluctuate by 10 pounds or more? □ Yes □ No
How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never
Do you avoid any particular foods? □ Yes □ No If yes, types and reason: _____
_____
If you could only eat a few foods a week, what would they be? _____
_____
Do you do the grocery shopping? □ Yes □ No If no, who does? _____
Do you read food labels? □ Yes □ No
Do you cook? □ Yes □ No If no, who does? _____
How many meals do you eat out per week? □ 0 – 1 □ 1 – 3 □ 3 – 5 □ > 5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

□ Fast eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% of meals away from home
□ Travel frequently
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience items
□ Poor snack choices
□ Significant other/family members don't like healthy foods
□ Significant other/family members have special dietary needs/food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship with food
□ Struggle with eating issues
□ Emotional eater (eat when sad, lonely, depressed, bored)
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____
_____
_____

SMOKING

Do you currently smoke? □ Yes □ No How many years? _____Packs per day?_____
Have you ever attempted to quit? □ Yes □ No If yes, how many times? _____
If a previous smoker: How many years?_____ Packs per day?_____
Have you experienced secondhand smoke exposure?_____

ALCOHOL INTAKE

Do you drink alcohol? □ Yes (□ Mild □ Moderate □ High) □ None
How many drinks do you currently have per week? *1 drink = 5 oz of wine, 12 oz of beer, 1.5 oz of spirits*
□ None □ 1 – 3 □ 4 – 6 □ 7 – 10 □ > 10 *If NONE, skip to Other Substances*

OTHER SUBSTANCES

Caffeine Intake: □ Yes □ No Coffee cups/day_____ Tea cups/day_____
If you drink coffee, what type? □ Regular □ Decaf
If you drink tea, what type? □ Black □ Herbal □ Caffeinated □ Caffein-free
Sodas: □ Regular □ Diet How many 12 oz servings/day_____
List favorite type:_____
Are you currently using any recreational drugs? □ Yes □ No Type: _____
Are you currently using any CBD oil or gummies? □ Yes □ No Type: _____

EXERCISE

Activity	*Type*	*Frequency per week*	*Duration in Minutes*
Stretching			
Cardio/Aerobics			
Strength			
Low Impact (Yoga, Pilates, Tai Chi, etc.)			
Sports (golf, tennis, etc.)			
Leisure Activities (Dancing, gardening, fishing, etc.)			
Other			

Rate your level of motivation for including exercise in your life right now: □ Low □ Medium □ High
List problems that limit activity:_____
_____
Do you feel unusually fatigued after exercise? □ Yes □ No Describe:_____
Do you usually sweat when exercising? □ Yes □ No

STRESS/COPING

Do you feel you have an excessive amount of stress in your life? □ Yes □ No
Do you feel you can easily handle the stress in your life? □ Yes □ No
Rate these daily stressors on a scale of 1 – 10: (1 being low & 10 being high)
Work_____Family_____Social_____Finances_____Health_____Other_____
Do you practice meditation or relaxation techniques? □ Yes □ No How often?_____
Check all that apply: □Yoga □Meditation □Imagery □Breathing □ Tai Chi □ Prayer □ Other_____

SLEEP/REST

Average number of hours you sleep per night? _____ What time do you typically go to bed? _____
Do you have trouble falling asleep? □ Yes □ No What time do you typically wake up? _____
Do you feel rested upon awakening? □ Yes □ No
Do you have problems with insomnia? □ Yes □ No
Do you snore? □ Yes □ No
Do you use sleep aids? □ Yes □ No Describe: _____

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? □ Yes □No If yes, describe symptoms: _____
_____
Do you have any food sensitivities (not allergies)? □ Yes □ No If yes, please list: _____
_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches and Pains □ Acid or sour stomach
Do you adversely react to (*Check all that apply)*:
□ Monosodium Glutamate (MSG) □ Aspartame (NutraSweet) □ Bananas □ Garlic □ Onion
□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red wine
□ Sulfite containing foods (wine, dried fruit, salad bars) □ Preservatives (ex. Sodium benzoate, etc.)
□ Other _____
Which of these significantly affect you? *Check all that apply:*
□ Cigarette smoke □ Perfumes/Colognes □ Auto exhaust fumes □ Other_____
In your work or home environment, are you exposed to: □ Chemicals □ Electromagnetic radiation □ Mold
Have you ever been told you have a liver disorder? □ Yes □ No
If yes, please explain: _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides (frequent exterminator visits) □ Pesticides □ Organic solvents
□ Heavy metals □ Other_____
Have you ever been tested for heavy metals □ Yes □ No If yes, how long ago? _____
Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? □ Yes □ No

DIGESTION (CONT)

□Upper Abdominal Pain
□Vomiting
□Intolerance to:
- □ Lactose
- □ All Dairy Products
- □ Wheat
- □ Gluten (Wheat, Rye, Barley)
- □ Corn
- □ Eggs
- □ Fatty Foods
- □ Yeast

□ Liver Disease/Jaundice (Yellow Eyes or Skin)
□ Abnormal Liver Function Tests
□ Lower Abdominal Pain
□ Mucus in Stools
□ Periodontal Disease
□ Sore Tongue
□ Strong Stool Odor
□ Undigested Food in Stools

SKIN PROBLEMS

□ Acne on Back
□ Acne on Chest
□ Acne on Face
□ Acne on Shoulders
□ Athlete's Foot
□ Bumps on Back of Upper Arms
□ Cellulite
□ Dark Circles Under Eyes
□ Ears Get Red
□ Easy Bruising
□ Lack of Sweating
□ Eczema
□ Hives
□ Jock Itch
□ Lackluster Skin
□ Moles w/ Color/Size Change
□ Oily Skin
□ Pale Skin
□ Patchy Dullness
□ Rash
□ Red Face
□ Sensitivity to Bites

SKIN PROBLEMS (CONT)

□ Sensitivity Poison Ivy/Oak
□ Shingles
□ Skin Darkening
□ Hair Loss
□ Vitiligo

ITCHING SKIN

□ Skin in General
□ Anus
□ Arms
□ Ear Canals
□ Eyes
□ Feet
□ Hands
□ Legs
□ Nipples
□ Nose
□ Genital area
□ Roof of Mouth
□ Scalp
□ Throat

SKIN, DRYNESS OF

□ Eyes
□ Feet
- □ Cracking
- □ Peeling

□ Hair
- □ Brittle

□ Hands
- □ Cracking
- □ Peeling

□ Mouth/Throat
□ Scalp
- □ Dandruff

□ Skin in General

LYMPH NODES

□ Enlarged/neck
□ Tender/neck
□ Other Enlarged/Tender

NAILS

□ Bitten
□ Brittle
□ Curve Up
□ Frayed
□ Fungus - Fingers
□ Fungus - Toes
□ Pitting
□ Ragged Cuticles
□ Ridges
□ Soft
□ Thickening of:
- □ Fingernails
- □ Toenails

□White Spots/Lines

RESPIRATORY

□ Bad Breath
□ Bad Odor in Nose
□ Cough - Dry
□ Cough - Productive
□ Hoarseness
□ Sore Throat
□ Hay Fever:
- □ Spring
- □ Summer
- □ Fall
- □ Change of Season

□ Nasal Stuffiness
□ Nose Bleeds
- □ Post Nasal Drip

□ Sinus Fullness
□ Sinus Infection
□ Snoring
□ Wheezing

CARDIOVASCULAR

□ Angina/Chest Pain
□ Breathlessness
□ Heart Murmur
□ Irregular Pulse
□ Palpitations
□ Phlebitis
□ Swollen Ankles/Feet
□ Varicose Veins

URINARY

□ Infection
□ Kidney Disease
□ Leaking/Incontinence
□ Kidney Disease
□ Pain/Burning
□ Urgency

FEMALE REPRODUCTION

□ Breast Cysts
□ Breast Lumps
□ Breast Tenderness
□ Ovarian Cyst
□ Poor Libido (Sex Drive)
□ Vaginal Discharge
□ Vaginal Odor
□ Vaginal Itch

FEMALE (CONT)

Premenstrual:

□ Bloating
□ Breast Tenderness
□ Carbohydrate Cravings
□ Chocolate Cravings
□ Constipation
□ Decreased Sleep
□ Diarrhea
□ Fatigue
□ Increased Sleep
□ Irritability

Menstrual:

□ Cramps
□ Heavy Periods
□ Irregular Periods
□ No Periods
□ Scanty Periods
□ Spotting Between

Procrastinating on making positive changes in diet and lifestyle is often rooted in comfort with the current situation, even when we know it's not the healthiest choice. There's a powerful allure to routine, and breaking out of it requires energy, motivation, and a level of self-discipline that can feel daunting. Additionally, the benefits of these changes are often delayed, while the effort required is immediate, which can make it harder to take action.

Every day that passes without action is a missed opportunity to improve health, energy, and quality of life. By postponing, we not only delay potential benefits but also risk ingraining poor habits more deeply. Often, the first step is the hardest, but small, gradual changes can build momentum. Rather than aiming for a complete overhaul, starting with achievable, enjoyable changes can create a sustainable foundation for lasting improvement.

- *Dr. Lisa James*

READINESS ASSESSMENT *Rate on a scale of 5 (very willing) to 1 (Not at all willing)*

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

Significantly modifying diet..... □ 5 □ 4 □ 3 □ 2 □ 1
Taking nutritional and/or herbal supplements each day..... □ 5 □ 4 □ 3 □ 2 □ 1
Try to journal your meals and snacks 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
If not already, try to engage in regular exercise..... □ 5 □ 4 □ 3 □ 2 □ 1
Comments_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities?
□ 5 □ 4 □ 3 □ 2 □ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

_____

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
Comments _____

_____

_____

MSQ – MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

Name: _____ Date: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total 0

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total 0

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

Total 0

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total 0

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)

Total 0

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total 0

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total 0

JOINTS/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness

Total 0

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total 0

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities

Total 0

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total 0

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total 0

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total 0

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight

Total 0

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total 0

GRAND TOTAL 0

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

CONSENT, DISCLOSURE, RELEASE AND WAIVER OF LIABILITY AGREEMENT

I, _____ the undersigned (client), acknowledge that I have read and understood the contents of this agreement.

Dr. Lisa James, makes no representations, claims, or guarantees regarding the efficacy of her recommendations. The recommendations are based upon a combination of her functional and nutritional medicine knowledge and education.

1. A consultation as provided by Dr. Lisa James does not constitute a medical service or health care treatment. Dr. Lisa James is **not** a medical doctor (MD) but does have her PhD in Functional Medicine & Blood Chemistry, as well as, Nutritional Medicine; she is also a trained Certified Autoimmune Holistic Nutrition Specialist, and a Board-Certified Functional Medicine Practitioner. The advice, education, and recommendations she provides are not only science-based but evidence-based. With the proper guidance, the human body is designed to correct and heal itself.

2. Individualized recommendations are offered and applied as an educational and informative consultation, and are intended for maintaining prevention of illness and general well-being. They are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. Any action taken as a result of the consultation is done at the sole discretion of the client. Therefore, it is strongly recommended that in addition to any health consultation that you maintain a relationship with your primary care provider (MD, DO, or NP) qualified to diagnose and treat your current health condition(s).

3. By signing this informed consent you agree to forever release Dr. Lisa James, from any and all actions, claims or demands that you may have in the future related in your participation of a functional health consultation and/or services.

4. Your signature verifies that you have **not** been told to discontinue treatments with any other medical specialists or other health care providers. Your signature is being given prior to rendering any service, advice, and/or recommendations whatsoever.

5. **Supplements**

Dr. Lisa James, makes available nutritional supplements and other health products. They are simply suggestions based on your consultation. You are in no way obligated to purchase these products through our website or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish. Please note the supplements suggested are professional-grade supplements to ensure the highest quality, purity, and effectiveness for targeted wellness support. These formulations are rigorously tested and sourced to meet clinical standards for optimal health outcomes.

6. **Payment**

Consultations and/or services provided by Dr. Lisa James, are **not** covered by any insurance plans; therefore, they cannot be turned into your insurance company or HSA/FSA account for reimbursement. By signing this form, you accept full financial responsibility for all costs associated with consultations and/or services including laboratory tests or kits ordered.

8. **Follow up**

It is the responsibility of the client to follow up for results of all testing and laboratory procedures. It should not be assumed on the part of the client that if they are not contacted by Dr. Lisa James, or if the client does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further health recommendations and/or advice. Health recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

9. **Cancelled or Missed Appointments**

Your appointment time is reserved specifically for you. A late cancellation or missed appointment leaves a hole in the practitioner's day that could have been filled by another client. Therefore, we require any cancellations or changes to your scheduled appointment(s) must be made at least 48 business hours (does not include weekends) prior to the scheduled appointment. Clients who provide less than a 48 business hour notice, or miss their appointment, will be charged the full fee of your appointment. This applies for any scheduled appointment either virtually (Zoom) or by phone.

CLIENT ACKNOWLEDGEMENT

I have read the Agreement and Informed Consent and I understand its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form.

I understand this consent agreement and fully understand the contents herein. I signed and have executed it freely and willingly.

Signature of Client: _____

Name: _____ Date _____

(please print)