

LISA JAMES, DFM, PHD

Board Certified Functional Medicine Practitioner
Certified Autoimmune Nutrition Specialist

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 completely filled out, signed, and emailed back to me **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:

drisajamesphd@gmail.com

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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:

<i>Describe Problem</i>	<i>Mild/ Moderate/ Severe</i>	<i>Prior Treatment/Approach</i>	<i>Any Success? Yes or No</i>

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? _____

WOMEN'S HISTORY

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? _____

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

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: _____

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

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 ☐ Caffeine-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

GENERAL

- ☐ Cold Hands and Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain

- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches:
 - ☐ Around Eyes
 - ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Difficulty:
 - ☐ Concentrating
 - ☐ with Balance
 - ☐ with Thinking
 - ☐ with Judgment
 - ☐ with Speech
 - ☐ with Memory
- ☐ Dizziness
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
 - ☐ Frequent Dieting
 - ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Cravings (breads/pasta)
- ☐ Sweet Cravings (cookies/cakes/candy)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of:
 - ☐ Lower Abdomen
 - ☐ Whole Abdomen
 - ☐ Bloating After Meals
 - ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corners of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea

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
- ☐ Bloating feeling
- ☐ Belching or passing gas
- ☐ Heartburn
- ☐ Intestinal/Stomach pain

Total _____

EARS

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

Total _____

EMOTIONS

- ☐ Mood swings
- ☐ Anxiety, fear or nervousness
- ☐ Anger, irritability or aggressiveness
- ☐ Depression

Total _____

ENERGY/ACTIVITY

- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness

Total _____

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 _____

HEAD

- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

Total _____

HEART

- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

Total _____

JOINTS/MUSCLES

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

Total _____

LUNGS

- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficult breathing

Total _____

MIND

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

Total _____

MOUTH/THROAT

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

Total _____

NOSE

- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation

Total _____

SKIN

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

Total _____

WEIGHT

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

Total _____

OTHER

- ☐ Frequent illness
- ☐ Frequent or urgent urination
- ☐ Genital itch or discharge

Total _____

GRAND TOTAL _____

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)