FREEDOMAGE

Functional Medicine and
Weight & Age Management Clinic

Name: ________________________ Age: _____ Height: ____ ft ____ inches

Mobile: _______________ Email ID: ________________________

Alternate Email ID: ______________________ Postal Address: _______________________

____

Sex: Male ☐ Female ☐ Occupation: _____________________

Current Weight: ____Kgs

Waist circumference_______ inches Hip circumference _______ inches

Body Fat%: ________

HEALTH HISTORY QUESTIONNAIRE

Welcome to our practice, please complete the following to the best of your ability:

Current health status	
How healthy are you now? Rank 1-10 (1=very unhealthy/10=very healthy):	
How often did you consult a medical professional in the past year?	Date of last exam:
Top 3 current health problems:	Severity 1-10 (1=not so bad/10=very bad):
1.	
2.	
3.	

ANY INTENSE CRAVINGS? Please list on the right. (Viz. chocolate, fried foods, soda, milk etc.)

TOP 3 HEALTH GOALS:

1.	
2.	
3.	

Personal Health History

Please indicate blood group (A/B/O/AB(+/-)		Height		Weight	
Any childhood illness (please indicate Y/N to the right):	Measles Chickenpox	Mumps	Rubella	Rheumatic fever	Polio

List of medical diagnosis

Year	Diagnosis

List of surgeries

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Medical and Allergies

Current medication list: please list your prescribed drugs and over the counter drugs (vitamins, inhalers etc.) if you do not know the name of the medication, please indicate the type (e.g. for heart condition, high blood pressure, pain pills etc.)

Name	Strength	Frequency taken

Any Allergies to Medications:

Name	Reaction

Other Allergies / Food Sensitivities:

Name	Reaction

Family Health History

Illness: Is there a history of any of the below mentioned health problems in your family? Please indicate Y/N. If other, please specify:

Heart disease: Obesity: Cancer:			Metabolic Syndrome: High Cholesterol: High blood sugar			Diabetes: Stroke: None:		Other:
	Age	Health issue		Age	Health issue		Age	Health issue
Father			Grandfather			Sibling 1		
Mother			Grandmother			Sibling 2		

HEALTH HABITS

Please indicate 1) Y/N below and 2) explain how often.

Exercise	Do you exercise?	How often?
Diet	Do you dieting?	How long?
Soda	Do you drink soda?	#of cups/cans per day?
Alcohol	Do you drink alcohol?	If yes, what kind? How often?
Smoking	Do you smoke?	If yes, what kind? How many/day?

OTHER PROBLEMS

Problem areas: Please indicate if any below

Head / Neck	Lungs	Bladder
Ear	Chest/ Heart	Back
Nose	Intestine	Skin
Throat	Bowel	Circulation

Any recent changes in

Weight	Ability to sleep	Mood
Energy level	Other pain / discomfort	

DIET HISTORY QUESTIONNAIRE

DIET: Vegetarian ☐ Non Vegetarian ☐ Egg Veg ☐

USUAL DIET INTAKE (not favorite but usual diet): North Indian /South Indian/Continental

TYPE OF DIET YOU WISH TO OPT FOR

Simple Healthy Weight Loss ☐ Weight Gain ☐

Anti Aging ☐ Anti Hypertensive ☐ Hyperuricemia ☐

Anti Diabetic ☐ Anti Cancer ☐ Post menopausal ☐

Hyperthyroidism ☐ Hypothyroidism ☐ Alcohol dependence ☐

Dyslipidemia ☐ Pregnancy & Lactation ☐ Neurological disorders ☐

Autism / Hyperactivity ☐ Auto immune disorder ☐ Chronic renal failure ☐

ANY KNOWN FAMILY HISTORY OF:

Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Thyroid ☐ Cancer ☐

ANY KNOWN HISTORY OF (SELF):

Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Thyroid ☐

ACTIVITY LEVELS

Any Weekly / Daily exercise regime? ______________________________________

Walk _____ (km / mins) daily / weekly Treadmill _____ (km / mins) daily / weekly

On the job requires: zero activity / moderate activity level / brisk activity level

- Any regular medication taken (specify name and dosage):-

____

- List down usual breakfast (Items &Quantity)

____

- List down usual Lunch (Items & Quantity)

____

- List down usual Dinner (Items & Quantity)

____

FAVOURITE FRUITS:

____

ALCOHOL CONSUMPTION:

_________ml daily / weekly (specify the drink) ______________________________________

- Wine Red /White ☐ Vodka ☐ Whisky ☐ Rum ☐
- Soft drinks / Juices: ______ glasses daily / weekly

- Average consumption of Tea / Coffee per day: _____ cups, usually taken with sugar / without sugar, usually taken with milk (full cream/Skimmed) / without milk.

LIST YOUR FAVORITE PARTY FOOD (Continental, south Indian, North Indian)

____

How often do you go to a restaurant / party? _______ times per week / month

WRITE DOWN THE MINIMUM QUANTITY OF ANY FOOD/DRINKS, WHICH YOU FEEL YOU CANNOT DO WITHOUT:

____

TICK YOUR PREFERENCES:

BREAKFAST:

Egg Omelet/ boiled/Scrambled / Egg whites / French toast ☐

Sandwich Cheese / Veg / Potato ☐

Bun / Bread Jam / butter / Chutney ☐

Milk Skimmed / Soya /Fruit Shake / Cold Coffee ☐

Hot Chocolate / Horlicks ☐ Fruit Yogurt ☐ Idli ☐

Fruit Muffin ☐ Oat Cookies ☐ Suji Rusk ☐

Oats / Corn / wheat flakes / Muesli ☐ Vermicelli Upma / Rava upma ☐

Wheat porridge with milk / veg ☐ Poha ☐ Besan / Dal chilla ☐

SNACKS:

Cold coffee ☐ Fruit shakes ☐ Tea / Coffee ☐ Juice / Fruit ☐

Wheat Khakra ☐ Fruit cake ☐ Suji Rusk ☐ Egg / French toast ☐

Granola Bar ☐ Muffin ☐ Idlis ☐ Dhokla ☐

Marie / Monaco / Mc Vities / Nutrichoice / Oats Biscuit / Hide n seek ☐

Aloo chaat ☐ Sprouts ☐ Cheese toast ☐

Oats Sachet ☐ Sweet Potato ☐ Wheat crackers ☐

Besan / Dal chilla ☐ Soup ☐ Vegetable juice ☐

Almonds / Cashews / Walnuts / Pistachios ☐ Coconut Water / Buttermilk ☐

DESERTS:

Specify if any: ____

LUNCH / DINNER:

Wheat / Missi Roti ☐ Wheat / Garlic breads ☐ Stuffed vegetable chapatti ☐

Uttapam ☐ ☐ Idli ☐ Dosa (Plain / Masala) ☐

Curd ☐ Vegetables ☐ Stir fried vegetables ☐

Dal palak / Chana / Rajmah / Chole ☐

Spinach / Tomato / Brocolli / Mushroom / Dal / Mixed veg soup ☐

Any other type of salad (specify) ____________________

Kathi Roll Chicken / Veg ☐ Subway / Grilled sandwich ☐ Pitta Bread & hummus ☐

Aloo Chaat ☐ Pav Bhaji ☐

Brown / Wheat Pasta ☐ Brown Rice ☐

Moong dal khichri ☐ Porridge (Veg / Milk) ☐ Dahi-Vada ☐

Chicken / Fish Tikka ☐ Chicken / Fish salad ☐ Chicken sandwich ☐

Chicken Minced chapatti ☐ Grilled / roasted chicken / Fish ☐

Chicken soup ☐ Chicken kathi roll ☐

Chicken / Fish curry / Stew ☐ Prawns / Shrimps ☐ Roasted Pork ☐

OTHER INFORMATION

Any dependence

Alcohol ☐ Smoking ☐ Sleeping Pills ☐ any other drug ☐

To be filled by the nutritionist after examination

Type of fat distribution: Insulin ☐ Estrogen ☐ Cortisol ☐

THYROID SYMPTOM SURVEY

Do you suffer from any of the following?

Please Rank your symptoms below on a scale of 0 to 3. (None, 1-Mild, 2-Moderate, 3-severe)

HYPO	RANK	HYPER	RANK
1.Tiredness & Sluggishness, lethargic		1.Tachycardia (Rapid or irregular heart beat)	
2.Dryer Hair or Skin (Thick, dry, scaly)		2.Palpitations (Skipping of heart beat)	
3.Sleep More Than Usual		3.Insomnia	
4.Weaker Muscles		4.Shakiness	
5.Constant Feeling of cold (fingers / hands /feet)		5.Increased Sweating	
6.Frequent Muscle Cramps		6.Brittle Nails	
7.Poorer Memory		7.Loss of Appetite	
8.More Depressed (mood change easily)			
9.Slower Thinking			
10.Puffier Eyes			
11.Difficulty with Math			
12.Hoarser or Deeper Voice			
13.Costipation			
14.Coarse Hair/Hair loss/ brittle			
15.Muscle/Joint pain			
16.Low Sex Drive/Impotence			
17.Puffy Hands and feet			
18.Unsteady Gait(bump into things)			
19.Gain Weight Easy			
20.Outer third of eyebrows thin			
21.Menses More Irregular (should be 28 days) (F only)			
22.Heavier Menses(clotting / 3+ days)(F Only)			
23.Carpel Tunnel Syndrome			

Total HYPO Score **Total HYPER Score**

For Client to fill Out -Cortisol	Y N	For Client to fill Out-Iodine	Y N
1.Wake up tired		1.Fibrocystic Breast / lumps or ovarian cysts	
2.wake up full of energy		2.Goiter Bulge or Band Around the neck	
3 to 4 pm feel tired, seek		3.Slow Speech	
snack/Tea/Coffee/coke		4.Enlarged tongue	
4.Fall asleep in front of TV/reading/computer		5.Puffy Face Puffy Hands	
5.As soon as I go to bed-Drop to sleep		6.Do you use Iodized salt	
6.Need to read 10 to 15 mins to drift into		7.Do you eat seafood 4 plus times per week	

sleep			

THYROID SYMPTOM SURVEY

FOR OFFICIAL USE ONLY;

RESULT			
Symptom Score HYPO/HYPER		12.5mg Iodine/Iodide	
		Thyroid Support	
Resting Metabolic Rate(RMR)		Adrenal Support	

Reference RMR % Reflex Response Abnormal		Reflex Response (F-PF)	
RMR(Woman) =		HYPOTHYROIDISM	>150 msec
RMR(Men) =		HYPERTHYROIDISM	<52 msec
Reflex =		Optimal	(52-100)(B/L136-150msec)
*(+/-250 cal./day for an over/under weight or aged patient)			

Check Here For; Antibodies Test (Hypo=12+, Hyper=7+ , Incl. Tach. Or Palp.)

RMR will increase about 400 calories above baseline (before treatment).

HORMONE SCREEN

(Kindly fill the questionnaire for female over 35 years old)

Date of last menstrual period;			Yes	No
Progesterone	1	Poor Sleep		
	2	Anxiety or Panic Attacks		
	3	Painful or Swollen breasts		
	4	Mood Swings(irritability)		
	5	Breast Cyst, Ovarian Cysts or Fibroids		
	6	Low Sex Drive		
	7	Hot Flashes		
	8	Heavier Bleeding or painful bleeding or irregular periods		
	9	Suffer from PMS(+ / - headaches)		
	10	Mild-abdominal Weight gain(+ / -bloating before period)		
Estrogen-High	1	Bloating, Puffiness or water retention		
	2	Rapid weight gain especially hips and butt		
	3	Migraine or other Headaches		
	4	Depression, weepiness or mood swings		
	5	Endometriosis, Fibroids or Gallstones		
	6	Heavy or Postmenopausal Bleeding		
	7	Increased bra size or breast tenderness		
	8	Red flush on face or rosacea		
	9	Insomnia		
	10	My mind is less sharp		
Estrogen-Low	1	Hot-flashes or Night sweats		
	2	Vaginal Dryness or painful sex		
	3	Urinary Incontinence or bladder infections		
	4	Brain Fog or poor memory(+/-depression)		
	5	Bone loss or Achy joints		
	6	Low Libido		
	7	I have more facial hair or losing hair from scalp		
	8	Wrinkles especially around my lips		
	9	My breasts are smaller and more droopy		
	10	Trouble sleeping or waking up in the middle of the night		
		Total		

HORMONE SCREEN

____

(Kindly fill the questionnaire for male over 35 years old)			
1	I'm often tired	Yes	No
2	I have fewer early morning erections		
3	I have lost a lot of strength		
4	My mind feels less sharp		
5	I think about sex less often		
6	My belly has much more fat		
7	I feel more down and sad at times		
8	My orgasms are less satisfying		
9	My erections are less hard		
10	I feel less confident		
	TOTAL		

MEDICAL CARE AND TREATMENT CONSENT

General Understanding:

I understand that FREEDOM AGE employs and specializes in diagnostic and therapeutic methods that may be known as: "age management", "wellness" medicine.

Informed consent:
I have reviewed the benefits, options and opportunities of this program; as well as clearly understand and agree to the planned treatment. It is accepted, acknowledged and understood, that I have had an opportunity to ask questions and to request additional information. I do consent to allowing my picture to be taken if required and placed in my patient file **for identification purposes**, I also consent to ancillary support staff performing diagnostic and treatment procedures on me that are prescribed or recommended by Freedom Age physician.

Patient Evaluation;

I understand that;(1) blood tests and urine may be ordered to better asses my chemical, hormonal and allergy status; and
(2) Other tests may be ordered as freedom Age deems necessary to asses and/or monitor my medical condition.

Treatment;

I understand that freedom Age may prescribe any of the following for my medical condition(s); hormones, herbs, vitamins minerals, amino acids, fish oil, marine plasma, nutraceuticals, injections (e.g. testosterone, Glutathione, Detox drips and IV multivitamins) or other innovative approaches that freedom Age deems medically necessary for the treatment of my medical condition(s).

1. For the Bio-identical Hormones Program (BHRT); I authorize Freedom Age, its physicians, associates and other personnel, to perform Hormonal Assessment and Treatment, and/or to do any other procedure that in their judgement may be advisable my wellbeing, including such procedure as are considered medically advisable to obtain the maximum benefits with the least risks, in regards to the proposed Bio identical Hormone Replacement Program.

2. Risks and Guarantees; I am aware that, since the practice of medicine is not an exact science, there are risks involved in any procedure or treatment. I am satisfied with my understanding of my specific risks of the bio identical hormone treatment and IV Chelation and Detox drips where applicable as prescribed by Freedom Age. This includes risks of cancer or other diseases in association with the use of any medical therapies provided. Additional risks include weight loss or gain, increased muscular mass, decreased body fat, hair growth change in hair color, hypoglycemia and disclosure of latent diabetes, transient fluid retention carpal tunnel syndrome, transient joint pain and headaches. I acknowledge that there is no guarantee or assurance that the results will be successful.

Insurance;

I understand that Freedom Age is a fee-for-service operation and does not accept insurance. Thus I am responsible for all charges incurred, although I may submit a claim form to my insurance company for reimbursement.

MEDICAL CARE AND TREATMENT CONSENT

Payment;

I understand that payment is due at the end of each visit unless a pre approved payment plan has been arranged with Freedom Age prior to treatment. I am aware that, if no program is joined, a charge of _Rs 1000 will apply as a doctor's consultation fee. Major credit cards, cheque or cash may be used to make payment.

No Treatment;

I am satisfied with my understanding of the possible consequence, outcomes or risks if no treatment is rendered.

Partial Invalidity;

If any term, provision or condition of this agreement or any, application thereof, should be held by a court of competent jurisdiction to be invalid, void, or unenforceable, all provisions and conditions of this agreement and all applications thereof not held invalid, void or unenforceable, shall continue in full force and effect and shall in no way be affected, impaired or invalidated thereby.

Limitation of medical care;

I understand that Freedom Age is providing a specific medical program e.g. BHRT, Diet, Age Management , Cardio Metabolic Program, Erectile Dysfunction etc. and that my Freedom Age physician is not taking responsibility for any other aspect of my ongoing medical health . My personal physician shall continue to provide all of my standard and continuous medical care. I hereby authorize the Freedom Diet physician to speak directly with my Primary Care physician when medically necessary, regarding my past and present medical care and treatment.

Patient Name;	**Patient Signature;**	**Date;**
Physician Name;	**Physician Signature;**	**Date**

I hereby give my willful and whole hearted consent to enroll in the Freedom Age ™ and indemnify any medical, legal or any other consequences thereof as a result of this plan

(Signature) **(Date)**

NOTE:

1. Any references of alcohol consumption and its quantities are not advised by Freedom Age ™. It is referred / mentioned purely on the willful need and desire for consumption expressed by the client.

2. Patients are requested to co-relate any dietary intake/treatment with their respective physician in case of any health condition or otherwise.