Initial Consultation Form

Please read these instructions before proceeding

Please fill out the information below and send it back to me via email to this address: russellmariani@thecenterforfunctionalnutrition.net

If for any reason, you can't EASILY fill out the form as a Word Document and send it back to me via email, let me know right away and I will send you a copied and pasted version of the Initial Consultation form. Some people find this format much easier to use. Any problems filling out the form? Call me: 413 313 3074.

Once I receive your filled out Initial Consultation form, I will phone you to set up a day and time for your Initial Consultation. This is a 90 minute phone consultation. Or Zoom, whatever your preference is. I am easy, either way.

Other Requests When Filling Out This Form: Please do not change the format. That is, keep it as a Word Document. Please do not convert it to a pdf. Please do not use the "Track Changes" function. Please use black ink only. I print these out and mark them up with hand-written notes. If you use any other color it does not print out and I can't read it.

Your form must be typed in black ink. Please do not scan a handwritten version.

Take your time. The more information you provide, the better. Please answer each item. Use as much space as you need.

Today's Date:

2/6/24

Your Name:

First Name Middle (Optional) Last Name

Mailing Address:

(optional) number, street, apartment number, post office box, city, state, zip code

Email Address:

Cell Phone Number:

Telephone Days: (work number)

Telephone Nights:

If I need to phone you what number should I use?

Referred by:

(How did you find out about me? Google Search? Your GI doctor? A friend?)

Your Age:

Your Date of Birth:

Your Height:

Your Current Weight:

The Weight You Would Prefer:

Your current occupation:

Your current relationship status:

Ages of your children: (if any)

Hobbies, or Your Primary Leisure Time Interests:

Any Major Life-Changes in the past few years?

What is the main health problem/challenge?

What are your primary symptoms?

Are there any secondary symptoms? (Or any other symptoms at all?)

Do you think the secondary symptoms are related to the primary symptoms?

When did these symptoms first appear?

Do you have any idea(s) why these symptoms first appeared?

Have you been given a medical diagnosis?

If yes, what is your medical diagnosis?

When was the date of your most recent medical diagnosis?

What diagnostic tests did you have that helped to confirm your current medical diagnosis?

Are you taking any doctor prescribed medications for this main health concern?

What were the results of your pharmaceutical-medication treatments?

Are you taking any medications for any other condition not already mentioned?

Have you received any other form of treatment for your current condition and symptoms?

What other (non-pharmaceutical) treatments have you received?

What were the results of these non-pharmaceutical treatments?

Women: Are you currently taking birth control pills?

Men: Are you currently taking medication for Erectile Dysfunction (ED)?

Have you ever done any Cleansing?

Have you ever done a Kidney Cleanse or a Liver Cleanse?

Have you ever tried fasting?

Have you ever tried Juice fasting?

Have you tried different “diets” in the past?

Please list any Nutritional Supplements you are taking and why you are taking them.

What is your most favorite food?

What is your most favorite beverage?

Describe your diet as a child.

What were your favorite snacks, desserts, beverages, indulgences?

This next section is very important

Describe your diet today.

My typical breakfast is:

My typical lunch is:

My typical dinner is:

What are your current favorite snacks, desserts, beverages, indulgences?

Do you exercise regularly?

Do you meditate?

Do you smoke cigars, a pipe, or cigarettes? (Give frequency)

Do you consume any alcohol?

Do you use a microwave oven at home or at work?

Do you consume caffeine?

Do you consume carbonated beverages?

Do you use artificial sweeteners?
(Specify type and frequency)

Do you consume “diet” drinks or “diet” sodas?

Do you eat three meals a day?

Number of meals per week eaten at home?

Number of meals per week eaten away from home?

Number of meals per week eaten at a restaurant?

Number of hours of sleep per night?

Describe the quality of your sleep:

Do you ever take mid-day naps?

Do you have a gas stove or electric stove?
(be specific by writing either “ gas ” or “ electric ”)

What kind of cookware do you have?

Do you consider yourself a good cook?

Have you ever taken cooking classes?

Do you have a history of any dental problems?

Do you currently have any mercury amalgam fillings?

Do you have any crowns, implants, etc?

Have you ever had a root canal?

What is the color of your “first of the morning” urine?

Any bladder/urination problems?

If you are female, any history of UTI's?

If you are male, any prostate problems?

How much water do you drink per day?

What kind of water do you drink?

Do you add sea salt to your drinking water?

Number of bowel movements in a typical day?

Provide a detailed description of your bowel movements here:

This Next Section is Very Important

What would you say are your worst or most insulting eating habits?

What would you say are your worst or most stressful lifestyle habits or lifestyle circumstances?

What would you say are your best or most complementary eating habits?

This Next Section is ALSO Very Important

How do you rate yourself in each item below? On a scale of 1-10, 10 being a state of perfect health and 1 being dead; how would you rate the functioning of each organ/system/feature/part? Put a single number to the right of each item. In the next section you will be able to list and describe symptoms related to each item.

Your digestive system in general:

Your teeth, mouth, gums:

Your throat:

Your stomach:

Your small intestine:

Your large intestine or colon:

Your kidneys:Your bladder:

Your nervous system:

Your brain, mind, mental functions:

Your spine:

Your bones:

Your joints:

Your muscles:

Your face, head, hair:

Your neck and shoulders:

Your arms and hands:

Your upper back:

Your lower back:

Your body above the waist:

Your body below the waist:

Your hips and buttocks:

Your upper legs:

Your knees:

Your calves:

Your ankles:

Your feet and toes:

Your sexual/reproductive organs/system:

Your heart:

Your circulation:

Your lungs:

Your skin:

Your hair:

Your toenails and fingernails:

Your eyesight/vision:

Your hearing:

Your sense of smell:

Your sense of taste:

Your sense of touch:

Next Section

Please put a check mark, or write the word “Yes” next to any of the following named conditions: If you currently have this condition please tell me when it started. If you once had a condition but no longer have it, tell me when you had it and for how long you had it. Feel free to describe your condition and symptoms and use as much space as you need.

Acne

Allergies

Asthma

Arthritis

Acid Reflux Disease

Appendicitis

Diverticulosis

Diverticulitis

Constipation

Colonic Inertia

Pelvic Floor Dysfunction

Diarrhea:

Irritable Bowel Syndrome (IBS)

Inflammatory Bowel Disease

Esophagitis

Barrett's Esophagus

Gastritis

Stomach Ulcers

H.Pylori

Crohn’s Disease

Colitis

Ulcerative Colitis

Proctitis

Ulcerative Proctitis

Hemorrhoids

Stomach Gas, Intestinal Gas

Eating Disorders

High Blood Pressure

Low Blood Sugar

Metabolic Syndrome

Diabetes

Lupus

Weight Control Issues
(can't gain, maintain, lose?)

High Cholesterol
(HDL is: LDL is:)

PMS
(Or other menstrual cycle problems, irregularities, conditions)

Menopause
(pre, post, in the middle of)

Male reproductive system problems
(be specific)

Female reproductive system problems
(be specific)

Hernia

Gout

Skin problems
(dryness, blemishes, acne, rosacea, eczema, psoriasis, dandruff, etc.)

Parasites

Yeast and fungus
(specify type)

Thyroid Problems

Tinnitis
(ringing in the ears)

Headaches
(Minor, moderate, migraine? Occasional? Regular? Chronic?)

Insomnia

Restless Sleep

Sleep Apnea

Nightmares

Depression

Anxiety

Bipolar Disorder

ADD/ADHD
(or any other focus and attention problems)

Fibromyalgia

Chronic Fatigue Syndrome

Urinary Incontinence

Fecal Incontinence

Kidney Stones

Gall Stones

Hepatitis

Ovarian Cysts

Uterine or Ovarian fibroids

Osteopenia
(If yes, give locations and numbers)

Osteoporosis
(If yes, give locations and numbers)

Heart Attack

Stroke

Any Surgeries?
(please specify procedure and dates)

Is there any condition or disease you have had that is not listed here?
(please explain)

Is there any history of cancer, heart attack, stroke, diabetes, alzheimers, or any other chronic degenerative disease in your family? (name the disease and who had it)

Is there any additional information you would like me to know about?
(Please use as much space as you need. Be as thorough as you need to be.)

If you had Aladdin's Lamp, what three health-related-things would you wish for?
(Be very specific)

1.

2.

3.

Once I receive your filled-out form via email, I will phone you to set up a time for your Initial Consultation. Your Initial Consultation will be a phone consultation or a Zoom session. It will take 60-90 minutes. The fee for the Initial Consultation is $500 which is paid in advance. Once your appointment day and time has been confirmed, I will send you an invoice via email (from PayPal). The subject line of the email will say: PayPal money request from the Center for Functional Nutrition. You may also see a return email address of:
meganmoore@thecenterforfunctionalnutrition.net
Megan Moore is co-director here at The Center.

I look forward to working with you. Please do not hesitate to call, text or email if you have any questions or need anything clarified as you are filling out this form. russellmariani@thecenterforfunctionalnutrition.net and my phone number is: 413-313-3074.

I look forward to speaking with you soon,

Russell Mariani

Health Educator and Digestive Wellness Expert
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413 313 3074 (texts only)