MAGGIE YU, M.D.
A Functional Medicine Practice

Welcome to the practice! Functional medicine is root cause medicine. We are excited that you will be working with our team to find out the root causes of your health issues. Our practice is structured radically different to ensure that you have the time, the right providers, the right education, and the right types of testing to ensure you get the results you need to feel great.

On your first visit you will be meeting with Maggie Yu, M.D. and functional nutritionist, Frankie Niwot. During that visit, your symptoms, previous work up, and extensive history will be taken to determine which medical and functional medicine tests are needed to identify the underlying causes of your health issues. Please fill out all the forms in this packet and bring it to your first visit. These forms are designed to help bring "your story" to life for us. We are focused on making connections in your health and family history that forms a cohesive story. Your story helps us identify the root causes of your symptoms. This first visit will take at least an hour. Please arrive 45 minutes early with all the forms completed to ensure that you complete our extensive intake process and that you are ready to get the full time on this visit.

We are not your traditional factory medicine clinic. You will learn about and experience a radically different and comprehensive approach to your health. You are going to meet and understand Dr. Yu's philosophy and style of practice. This will also serve as an extensive mutual interview where we both get to ask each other many questions to ensure that this is a great fit for both.

One great way to interact with our practice is through the new patient portal through Athena Health. You should have already received an invitation in your email. If you have not, please call us. You will be able to send direct messages to your provider, nutritionist, or health care team without having to call and in your own words. The portal is a great way for non-urgent communications and requests. Please sign up as soon as you can.

Here's to a new therapeutic partnership between you and your health care team. Welcome to a new approach to functional wellness. I can't wait to see you soon! Let's start your next chapter!

Maggie Yu ,M.D.

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Welcome! I wanted to take the opportunity to introduce myself so that you can make the most of your relationship with our practice!

I will now be joining your healthcare team. I am Frankie Niwot, your personal nutritionist. Whether you have worked with your nutritional health in the past or if this is a new chapter moving forward, the way nutrition works with Functional Medicine is different. I am writing to let you know the 'how,' the 'why' and the 'what' of what makes nutrition a *functional* part of your health journey.

Nutrition is an integral part of Functional Medicine because we believe that nutrition is one of the key foundations of health. Nutritional deficiencies are common for many reasons; including, long held eating habits, sugar overload and blood sugar imbalance. Each of these must be addressed in order to really move towards wellness. Nutritional deficiencies are often at the root cause of chronic illness so there is a lot of clarity that can come with an initial dietary intake.

So what will our sessions look like? My main role is support with making changes in how you are eating and what you are eating. The how is often overlooked in our fast paced life and eating can often get pushed to the back burner, crashing our blood sugar and leaving us grouchy or fatigued. These feelings can then lead to last minute choices or over eating to compensate. Blood sugar also has a large impact on hormonal and endocrine health. In addition, some patients need specialized dietary recommendations for food intolerance or gut infections. Whatever the current health concern, nutrition is often a part of the picture and can be drastically helped by increasing the right nutrient dense foods in your diet.

In our practice, Dr. Yu and I work as a close team to manage your concerns and provide certainty moving forward. Our initial sessions are seen together when possible to get a better understanding of health history. Together, we develop a step by step plan to support your health concerns. We discuss the best way to keep the diet diverse while eliminating triggers and food intolerances. Our approach is thoughtful of your schedule, living situation, history with food and dieting, so that our recommendations can be the ones that work.

Some of our tools include food intolerance testing, gut healing protocols for autoimmune conditions and gut infection diagnostic work up. With these tools we eliminate digestive upset or reactions that can feel random. By collecting the data points to address your unique condition, we are able to map out an individualized treatment plan with daily dietary recommendations. I also take into special consideration your relationship with food which may be based on your history with dieting and weight loss. With a positive relationship to food we are able to meet the full scope of your health needs, making nutrition a foundation of our approach.

In addition to our visits, I am also here to support your diet changes via our patient portal so feel free to reach out at any time! So excited to see you soon and to be a part of your functional medicine team!

All the Best,

Frankie Leigh Niwot

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Patient Information

Completion of this information in its entirety is required at time of visit

NAME_____Social Security #_____-____-_____DOB_____
Last First Middle

Mailing Address_____ _____ _____ _____
Street City State Zip

Primary Phone (_____)_____-_____ Secondary Phone (____) _____-_____ Work Phone (____) _____-_____

Employer_____Occupation_____

Highest Level of Education _____

E-mail Address_____

Marital Status (check one): Single___ Married ___ Divorced___ Separated____ Domestic Partner ____ Widow___

Race_____ Ethnicity: Hispanic___ Non-Hispanic ___ Refused___ Preferred Language_____

In Case of Emergency:

Name _____Phone (___) ____-_____
Relationship to patient_____

How do you intend to pay? **Cash Policy** **Insurance**

Primary Insurance Co._____ID#_____
Name of Insured_____DOB of Insured_____Group#_____
Insured's Social Security #_____
Secondary Insurance Co._____ID#_____
Name of Insured_____DOB of Insured_____ Group#_____
Insured's Social Security #_____

If someone other than the patient is responsible for payment (or is the primary insured), complete the following:

Name of the responsible party_____SSN# _____
Address_____DOB_____
Relationship to patient_____ Home Phone (___) _____-_____
Employer_____Address_____Work Phone (___)____-_____

Please Read, Initial in Box and Sign Below

☐ I authorize the office to provide my insurance companies all information necessary to process insurance claims and assign the office all of the insurance benefits due to me the full extent of my financial obligation. I understand that I am ultimately responsible for my balance if my insurance does not pay or for whatever portion is deemed patient responsibility. I am required to pay in full all balance due within 30 days of receipt or call the office to make payment arrangements. If it becomes necessary to effect collections for any amount owed on this or subsequent visits. I agree to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the office to release information necessary to secure payment.

☐ As a courtesy to all our patients, we require a 24 hour notice for cancellations and reschedules. For cancellations/reschedules/no-shows without adequate notice, there will be a charge of $100.00 that is not billable to insurance. We appreciate your courtesy in this matter.

☐ I authorize a monthly debit from my credit card for the Concierge Fee and understand that the Concierge Fee is separate from my insurance. There is no contract and cancellations need to be made prior to your recurring billing date. Reenrollment will be allowed based upon capacity of the clinic. I understand the fee is to pay for services above and beyond what my insurance covers.

☐ I authorize employees to leave messages at the following phone number in regards to results of tests (labs, diagnostic imaging) ordered by my provider. Phone # _____

☐ I, _____, give permission for the office to discuss my protected health information with the following persons.

Name / Relation _____ Phone (_____) _____-_____

Name / Relation _____ Phone (_____) _____-_____

Name / Relation _____ Phone (_____) _____-_____

☐ I authorize treatment deemed medically necessary. I understand that if there are specific procedures I am scheduled for that I will sign a specific consent for each procedure. This consent is for general treatment needed when scheduled for care.

☐ HIPPA regulations require us to make a good faith effort to obtain your written acknowledgment of receipt of the notice of privacy practices, please read and sign the following.

☐ We expect each staff member to treat each patient with courtesy and respect. We expect the same from our patients. We are here to assist you in your needs. We do not tolerate inappropriate behavior or language and engaging in such is cause for termination of care.

Signature_____ Date_____
(Patient signature or responsible party signature if patient is under 15 years of age)

Relationship of Representative:_____

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Authorization for Use and Disclosure of Protected Health Information

PATIENT IDENTIFICATION:

Name: _____

Date of Birth: _____

Address: _____

_____

SS #: _____

Telephone:_____

DATES OF HEALTH CARE TO BE RELEASED:

From (date) _____

To (date) _____

PERSON AUTHORIZED TO RECEIVE RECORDS:

Name: _____

Address: _____

Telephone: _____Fax: _____

PURPOSE OF REQUEST:

____ Treatment or Consultation _____ At the request of the patient ____ Billing or claims payment

_____ other: _____

PLEASE DON'T SEND RECORDS IN DISK FORM.

INITIAL TYPE OF INFORMATION TO BE RELEASED:

_____Laboratory test reports _____History and Physical Exam _____Radiology imaging reports

_____Radiology Imaging

Other: _____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Office of Dr. Maggie Yu. Unless revoked, this authorization will expire in 180 days or on the following date or event:

_____

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Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to: drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release.

Initial YES_____ Initial NO_____

I understand that if my medical or billing record contains information in reference to HIV / AIDS (Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Initial YES_____ Initial NO_____

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that The Office of Dr. Maggie Yu may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize the Office of Dr. Maggie Yu to use and disclose the protected health information specified above. All records within the last 2 years will be released unless otherwise noted:

Signature: _____ Date: _____

Relationship if not patient: _____

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A Functional Medicine Practice

NAME _____

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

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

Systems Assessment Form

Please circle the appropriate number "0-3" on all questions below. **<u>0 as the least/never</u> to <u>3 as the most/always.</u>**

Category 1
Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relief by passing stool/gas 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Pass large amounts of foul smelling gas 0 1 2 3

Category 2
Excessive belching and burping 0 1 2 3
Difficulty digesting fruits/vegetables, undigested foods in the stools 0 1 2 3

Category 3
Use antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Nausea and/or vomiting 0 1 2 3
Heartburn 0 1 2 3
if so, list triggers: _____
Heartburn when lying down or bending forward .. 0 1 2 3
Chronic sore throat or cough 0 1 2 3

Category 4
Greasy or high-fat foods cause distress 0 1 2 3
Bloating and distention 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed ..... Y N

Category 5
Crave sweets 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep yourself going/started 0 1 2 3
Get lightheaded if meals are missed 0 1 2 3
Feel shaky, jittery or have tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory/forgetful 0 1 2 3
Morning headaches/wake with headaches 0 1 2 3

Category 6
Eating sweets does not relieve cravings for sugar 0 1 2 3
Eating large meals causes immediate fatigue 0 1 2 3
Must have sweets after meal 0 1 2 3
Difficulty losing weight 0 1 2 3
Always hungry 0 1 2 3

Category 7
Cannot stay asleep 0 1 2 3
Crave salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3

Category 8
Cannot fall asleep 0 1 2 3
Under high amounts of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep 0 1 2 3

Category 9
Tired, sluggish 0 1 2 3
Feel cold – hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Gain weight easily 0 1 2 3

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NAME _____

(Category 9 continued)

Afternoon energy crash 0 1 2 3
Fullness of the throat/neck or rash 0 1 2 3
Depression, lack of motivation 0 1 2 3
Outer third eyebrow thins 0 1 2 3
Excessive hair loss 0 1 2 3
Dryness of skin/scalp/ eczema..... 0 1 2 3
Mental sluggishness 0 1 2 3

Category 10

Heart palpitations 0 1 2 3
Nervous and emotional 0 1 2 3
Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight or weight loss 0 1 2 3

Category 11

Diminished sex drive 0 1 2 3
Menstrual disorders or lack of menstruation 0 1 2 3
Increased ability to eat sugars without symptoms . 0 1 2 3

Category 12

Increased sex drive 0 1 2 3
Reduced tolerance to sugars 0 1 2 3
"Splitting" type headaches 0 1 2 3

Category 13 (Males only)

Urination difficulty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Decrease in libido 0 1 2 3
Decrease in spontaneous morning erections 0 1 2 3
Decrease in fullness of erections 0 1 2 3
Difficulty in maintaining erections 0 1 2 3
Spells of mental fatigue 0 1 2 3
Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decrease in physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips . 0 1 2 3

Category 14 (Females Only)

Menstruating ..... Y N
Alternating menstrual cycle lengths ..... Y N NA
Extended menstrual cycle, greater than 32 days . Y N NA
Shortened menses, less than every 24 days ..... Y N NA

(Females only continued)

Pain and cramping periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic fullness 0 1 2 3
Pelvic pain during menses 0 1 2 3
Rectal fullness or fibroids 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne breakouts 0 1 2 3
Fascial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3
Hot flashes 0 1 2 3
Insomnia 0 1 2 3
Mental fogginess 0 1 2 3
Orgasms harder to get to or weaker than they use to be 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Anxiety 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Increased vaginal pain, dryness or itching 0 1 2 3
Bowel change with periods 0 1 2 3

Category 15

Vaginal yeast 0 1 2 3
Skin fungus/itching/rash 0 1 2 3
Sensitive to the smell mold 0 1 2 3
Change in odor/breath that you or others have noticed 0 1 2 3

Category 16

Frequent or severe bladder infections 0 1 2 3
Chronic sinus infections 0 1 2 3
History of toxic shock syndrome 0 1 2 3

Category 17

Water retention/swelling 0 1 2 3
Dry eyes, eye irritation, sensitivity to light 0 1 2 3
Joint pain 0 1 2 3
Muscle soreness, trigger or tender points 0 1 2 3
Heal poorly from surgery/ injury 0 1 2 3
Poor circulation/numbness/whitening of fingertips 0 1 2 3
Skin/mouth ulcers 0 1 2 3
Psoriasis/Vitiligo 0 1 2 3

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NAME _____

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

_____

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

_____

Family Health History *please indicate current and past history to the best of your knowledge*

Check all family members that apply :	FATHER	MOTHER	BROTHER(s)	SISTER(s)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
Age (if still living)									
Age at death									
THYROID									
Goiter/Cysts									
High thyroid									
Low thyroid									
Thyroid cancer									
HORMONES									
Hysterectomy									
Heavy periods									
Osteoporosis									
Miscarriages									
MENTAL HEALTH									
ADD									
Anxiety									
Depression									
Bipolar									
Substance abuse									
Autism									
Other psych disorders									

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Check all family members that apply :	FATHER	MOTHER	BROTHER(s)	SISTER(s)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
AUTOIMMUNE DISEASE									
Diabetes									
Lupus									
Rheumatoid arthritis									
Sjogren's									
Multiple Sclerosis									
Fibromyalgia									
Chronic Fatigue									
Lyme Disease									
Vitiligo									
Lichen Sclerosus									
GUT PROBLEMS									
Irritable Bowels									
Ulcerative colitis									
Crohn's disease									
Celiac									
Food intolerances									
NEUROLOGICAL									
Parkinson's									
Epilepsy									
Dementia (age)									
ALLERGIES									
Asthma									
Seasonal/Envmnt									
Psoriasis									
Eczema									
CARDIOVASCULAR									
High blood pressure									
Stroke									
Heart attack									
High cholesterol									

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Diet Assessment

CHILDHOOD HISTORY

	Yes	No	Not Sure	Comments
Were you a full term baby?				
- premature				
- caesarean section				
First Diet				
- breast fed				
- formula fed				
When pregnant with you, did your mother:				
- smoke tobacco				
- use recreational drugs				
- drink alcohol				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Not Sure	Comments
Sugar? (sweets, candy, cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheese, dairy products?				
Vegetarian diet?				
Breads, pastas?				

As a child, were there foods that you had to avoid because they gave you symptoms? Y N

If yes, please explain: (Example: milk – diarrhea) _____

_____

Have you ever been tested for Food Intolerances? Yes ____ No _____ How? _____

if yes, please list the results? _____

Do you have a history of dieting? Yes ____ No _____ if yes, which ones _____

_____

_____

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Are you currently following a specific diet? _____

_____

Please list any foods you currently avoid and the known reaction to each. (Example: milk – diarrhea)

_____

_____

How many times a week do you eat out per week? _____

How many caffeinated beverages do you consume per day? _____

Lifestyle Assessment

HOME LIFE

Who do you currently live with? (relationship, name, age) _____

_____

If with a spouse/partner please list name and occupation: _____

Do all members of your house follow the same diet? Please explain. _____

_____

Do you feel supported in your household if diet needs to change? Please explain. _____

_____

Which of the following provide you emotional support?

____ Spouse ____ Family ____ Friends ____ Religious/Spiritual ____ Pet _____ Other

ALCOHOL INTAKE

How many alcoholic beverages do you drink in a week? _____

Have you ever had a problem with alcohol? Yes _____ No _____

If yes, indicate time period (month/year) from _____ to _____

Do you currently or have you previously used recreational drugs? Yes _____ No _____

If so what and how long? _____

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EXERCISE

Do you exercise regularly? Yes _____ No _____

	Times per week				Length of session in minutes			
If yes, please indicate:	1x	2x	3x	4x	≤ 15	16-30	31-45	> 45
Jogging/walking								
Aerobics								
Strength training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water)								
Other:								

If no, please indicate what problems limit your activity (lack of motivation, fatigue after exercising, etc.)

_____

_____

_____

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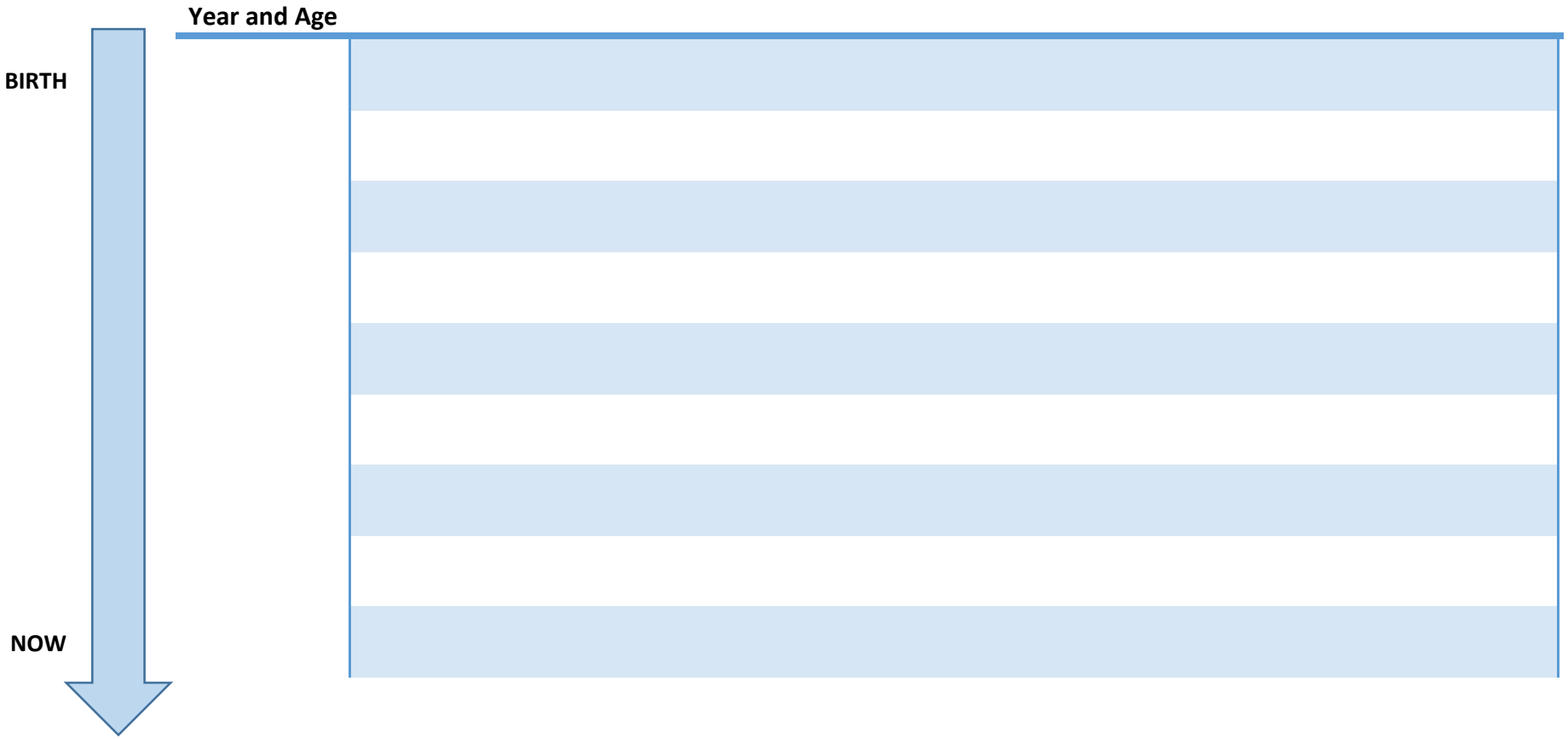
Health Timeline

Patient Name: _____

Please provide years and age for major health events.

Examples include: surgeries, infections, miscarriages, postpartum/depression, trauma



Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____Age: _____

Please indicate if there is a **personal or family history** of any of the following cancers. If yes, then **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Height: _____ Weight: _____ Age of First Period: _____ Age of First Child (if applicable):_____

Are You Menopausal: Yes (*at Age_____)* or No **Have you ever used Hormone Replacement Therapy?** Yes or No

Have you or anyone in your family had genetic testing for the BRAC panel or LYNCH panel? Yes or No

If Yes – who was tested and what were the results _____

Example: Colon Cancer Brother 36 yrs Aunt 44; Cousin 58 Grandfather 65

BREAST AND OVARIAN CANCER (HBOC)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	**N**	**Breast cancer**				
Y	**N**	**Breast cancer in both breasts OR multiple primary breast cancers**				
Y	**N**	**Ovarian cancer**				
Y	**N**	**Male breast cancer**				
		Are you of Ashkenazi Jewish descent? Please Circle:	**YES / NO**			

COLON AND UTERINE CANCER (LYNCH)

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
Y	**N**	**Uterine (endometrial) cancer**				
Y	**N**	**Colon cancer**				
Y	**N**	**Gastric/stomach cancer**				
Y	**N**	**Ovarian cancer**				
Y	**N**	**Kidney/bladder/ureter, brain or small bowel cancer**				
Y	**N**	**10 or more colon polyps in a lifetime**				
Y	**N**	**Prostate Cancer (HBOC)**				
Y	**N**	**Melanoma (HBOC)**				
Y	**N**	**Pancreatic Cancer (HBOC/Lyn)**				
Y	**N**	**Other Cancers**				

FOR OFFICE USE ONLY

Patient offered hereditary cancer testing?

☐ YES (ACCEPTED / DECLINED) ☐ NO HEALTH CARE PROVIDER SIGNATURE: _____

HBOC - Personal or Family History (Derived from NCCN)

One person with: (out to 2nd degree)

-Breast CA (diagnosed ≤45)
-Ovarian CA, any age
-Male breast CA, any age
-Bilateral breast CA (1st cancer dx'd ≤50)
-Triple negative Breast CA (dx'd ≤60)
-Known Mutation

Two persons with: (out to 2rd degree)

-Breast Cancer (at least 1 dx'd ≤ 50)
-Prostate or Pancreatic at any age with a breast cancer dx'd ≤ 50

Three Persons with: (out to 2rd degree)

-Combination breast/pancreatic/aggressive prostate cancer at any age

NOTE:

A. **Lower threshold for testing in Ashkenazi Jewish individuals.**

B. Limited family structure (fewer than 2 female 1st or 2nd degree relatives living past age 45)

Lynch*- Personal or Family History (Derived from SGO)

One person with: (out to 2nd degree)

-Female dx at any age with Endometrial CA
-Endometrial or Colorectal Cancer (1 diagnosed ≤50)
-CRC, endo, or ovarian cancer along with another Lynch associated cancer in the same individual (2 primaries, any age)

2 persons:

1 person with later onset (>50) endo or CRC and 1 person with an early onset (<50) other Lynch-related cancer

Three persons with: (out to 2nd degree)

-Lynch* cancers with 1 being Endometrial or Colorectal, any age

*Endo, CRC, ovarian, stomach, brain, pancreas, small bowel, ureter/ renal pelvis, biliary tract, sebaceous adenomas