

# Fenske Holistic Healthcare Center

## Functional Medicine Progress Questionnaire

Please complete this form about 1 week prior to your next office visit. Mail or fax it to our office in advance, otherwise remember to bring the completed form to your appointment.  
**Thanks!**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

The following questionnaire is a significant part of your program. May it be good, bad or indifferent; your communication with me on your progress plays a major role in how best to proceed. Each patient has a different viewpoint on how well they are progressing. Giving careful thought to your responses on each of the below symptoms will allow both you and me an opportunity to see eye to eye on how well you are doing.

My main objective in having you complete this progress questionnaire is to help you succeed in accomplishing your health goals. Please spend extra time on the **comment section**. Express your frustrations, what you like, what you dislike, your successes etc. This is your chance to tell me everything that is good and everything that frustrates you. I want to encourage you to reach deep down in your gut and tell it like it is. I want to re-assure you that your time in completing this valuable questionnaire will help me help you.

**Your Symptoms:** List your primary symptoms and grade your level of progress. Use the following Grading Scale: **(PLACE AN "X" in the APPROPRIATE BOX BELOW)**

- **Worse**
- **No Improvement** - (0% improvement)
- **Slightly Better** - (25% improvement) Symptoms are still present however, you either experienced a 25% reduction in duration or intensity of your symptoms
- **Good** - (50% improvement) Symptoms are still present, however, you either experienced a 50%+ reduction in duration or intensity of your symptoms
- **Excellent** - (No symptoms/100% improvement)

Symptoms	Worse	No Improvement	Slightly Better	Good	Excellent
EXAMPLE: <i>drowsiness</i>				X	
How is your energy?					

**In this box please update me on any new symptoms or health concerns.  
Use this box to record any and all details.**

**ADDITIONAL COMMENTS**

1. List any changes since your last visit in the medications (or their dosages) you are taking:
2. Have you altered any dosages of the nutritional supplements I recommended or are you taking supplements other than those I recommended? **Yes / No** If yes, what are the changes?
3. Have you had any blood tests or other diagnostic testing performed since your last office visit? **Yes / No** If yes, what have you had done?
4. Please comment on any concerns or questions about your symptoms. Basically, I want you to tell me if we have met your needs and expectations. Do you understand the role of nutritional/functional medicine testing in helping you get well?
5. Please list what you ate for breakfast, lunch and dinner over the last **TWO days**. I want to know exactly what foods and beverages you consumed over the last two days.
6. What has been your greatest vice/difficulty in sticking with my recommendations?
7. Do you have any other comments about your health?

Feel free to contact me at **(608) 836-8883** with any questions.  
Please take care,

*Nicole Fenske, D.C., C.C.N.*  
Dr. Nicole Fenske