

**AdventHealth Whole Health Institute
NUTRITION INTAKE FORM**

*Thank you for choosing us to be partners in your health. Please fill out this form completely and accurately for our dietitian to be able to best serve your interests and needs. All information received on this form is strictly confidential. **To reschedule or cancel your nutrition appointment, call 913-632-3550.***

Name: _____ Age: _____ DOB: _____

Gender: _____ Marital Status: _____ Primary Phone: _____

Primary Address:

Email: _____ Add email to our monthly e-newsletter: Yes No

Occupation: _____ Employer: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about us?

New patient: Yes No

Appointment Date: _____ Time: _____

Referred by: _____

Please list any physicians whose care you are currently under:

What are your primary health and nutrition concerns that you'd like to address today?

I agree to enroll into FullScript as a new patient at the Whole Health Institute to receive supplement recommendations from my provider. ***FullScript** is a virtual supplement dispensary and a comprehensive platform that integrative healthcare professionals use to dispense the best quality supplements.

HEALTH & MEDICAL HISTORY—Check all that apply by filling in box with C (current) or P (Past):

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Eating Disorder:	<input type="checkbox"/> IBD <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Food allergies or Intolerances	<input type="checkbox"/> IBS: Type:
<input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> GI Condition:	<input type="checkbox"/> Infertility
<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> GERD, Heartburn, Hiatal Hernia	<input type="checkbox"/> Pregnant or Trying to Conceive
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gout	<input type="checkbox"/> PMS / Dysmenorrhea
<input type="checkbox"/> Depression	<input type="checkbox"/> Hashimoto's Thyroiditis	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Arthritis <input type="checkbox"/> Osteo <input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Perimenopause
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Menopause
<input type="checkbox"/> Autoimmune Condition	<input type="checkbox"/> Grave's	<input type="checkbox"/> Memory concerns
<input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Neurological Disease:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Celiac disease	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> Prostate
<input type="checkbox"/> Gluten intolerance	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Overweight	<input type="checkbox"/> Urinary conditions:
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Concussion	<input type="checkbox"/> Other:

FAMILY HISTORY:

Family History unknown

Have any of your close relatives (parent, sibling, child, grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.

CONDITION	RELATIVE(S)	AGE OF ONSET
Heart Disease		
High Blood Pressure		
High Cholesterol		
Stroke		
Cancer (type)		
Overweight		
Other:		

Medications/Hormones/Weight Loss Meds	Dosage	Frequency	Date Started
Supplements (vitamins, minerals, herbs, medical foods, etc.)*	Dosage	Frequency	Date Started

**New patients, please bring in any vitamins, mineral, or herb supplements for review.*

WEIGHT HISTORY:

Height:	Current weight:	Weight 1 year ago:	Usual Adult Weight:
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Is weight loss/gain a goal of yours? Yes No Would you like to be weighed today? Yes No
 Have you recently lost or gained weight that you're concerned about? Yes No *If yes, please describe.*

FEMALE:

Are you currently or could be pregnant: Yes No Date of last menstrual period: _____

Have you ever been pregnant? Yes No How many times: ____ How many vaginal births: ____
 C-Sections: ____ Miscarriages: ____

Have your periods been regular: Yes No Infertility History? Yes No

Birth control methods used in the past: _____

Current birth control method: _____

Are you currently (circle one):

Pre-menopausal | Transitioning through menopause | Post-menopausal

Have you/are you, taking HRT: Yes No How long: _____

Have you ever had an abnormal pap smear result? If so, please explain _____

Any current or past gynecological issues? Yes No

Do you suffer from any PMS symptoms? If so, describe _____

LIFESTYLE:

Exercise/Activity: Yes No Type(s): _____

How often and how long?

Sleep Duration: 8+ hours 6-8 hours <6 hours Difficulty getting to sleep

Sleep Quality: Good Fair Poor Difficulty staying asleep

Sleep Apnea? Yes No

Rate your typical energy level: Excellent Good Fair Poor

Rate your stress on scale of 1 to 10 (1 = lowest. 10 = highest): _____

Do you have any practices that help reduce your stress? Yes No Please Describe:

Have you ever had psychotherapy/counseling? Yes No Currently

Alcohol use: No Yes

If yes, about how many drinks per week: 0 - 1 1 - 3 3 - 5 5+

Tobacco use: No Yes

If yes, please specify: Cigarettes Vaping Chewing tobacco Marijuana

Packs per day: _____ Number of years: _____

Type: _____

DIGESTIVE HEALTH:

Digestive function: Good Fair Poor Number of Bowel movements a day: _____

Please check all that apply: Describe: _____

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abdominal cramps or spasms | <input type="checkbox"/> Nausea / Vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Excess gas | <input type="checkbox"/> Appetite concerns |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Uncomfortable fullness | <input type="checkbox"/> Frequent antibiotic use |

Have you had a colonoscopy or endoscopy by a GI specialist? If so, were there any significant findings?

Additional digestive concerns? Please describe:

FOOD AND DIETARY HABITS:

Do you currently follow a special diet or nutritional program? No Yes If yes, please describe:

Are you aware of any adverse food reactions (allergies/intolerances)? No Yes

If yes, explain: _____

Are there any specific foods you dislike or avoid? No Yes If yes, please describe:

What percentage of meals do you eat out? 90-100% 75% 50% < 25% < 10%

Where? _____

Who does most of the grocery shopping in your household? _____

Where? _____

Who does most of the cooking in your household? _____

DAILY DIETARY INTAKE:

Example- Time: 8:15am Food items and amounts: 8 oz coffee, 1 tsp sugar, 1/2 bagel, 1 tbsp cream cheese

Time: _____

Food items and amounts:

Time: _____

Food items and amounts:

Time: _____

Food items and amounts:

Time: _____

Food items and amounts:

Time: _____

Food items and amounts:

Are you or have you followed any of these special diets?

Gluten-free: Yes No Currently

Dairy-free: Yes No Currently

Vegan: Yes No Currently

Vegetarian: Yes No Currently

Intermittent fasting: Yes No Currently

Keto: Yes No Currently

Low carb: Yes No Currently

Low fat: Yes No Currently

Other: _____

What do you think you struggle most with regarding your diet/health?

Anything else you'd like to share with me or discuss during your visit?

Office Location

AdventHealth Whole Health Institute is located on the AdventHealth South Overland Park campus.
Address: 7840 W. 165th Street, Suite 110, Overland Park, KS, 66223 Phone: 913-632-3550 / Fax: 913-632-3559
Email: SOP.WholeHealthInstitute@AdventHealth.com

Virtual Visits

Now offering virtual follow up visits. Patients must physically be in the state of KS and/or MO at the time of the visit.

Directions

From the North:

Take 69 Highway to 159th Street exit. Turn right or west on 159th Street. Get in the left lane and take the second left (Panera is on one corner; bank on the other corner) at the stoplight which is Lowell Avenue. Head South on Lowell avenue and go around 2 roundabouts and enter the AdventHealth South Overland Park campus. Go past the Emergency Department and head down the hill to the Medical Office Building (7840 W. 165th Street). Enter the building, the Whole Health Institute is Suite 110 and just to the left of the elevators on the ground floor.

From the South:

Take 69 Highway to the 159th Street exit. Turn left or west on 159th Street passing over the highway. Get in the left lane take the second left (Panera is on one corner; bank on the other) at the stoplight which is Lowell Avenue. Head South on Lowell avenue and go around 2 roundabouts and enter the AdventHealth South Overland Park campus. Go past the Emergency Department and head down the hill to the Medical Office Building (7840 W. 165th Street). Enter the building, the Whole Health Institute is Suite 110 and just to the left of the elevators on the ground floor.

Charges

Your initial visit will last 60 to 90 minutes, depending on which Provider you schedule with. Follow up visits are charged based on time. Follow up visits can be booked for 30 to 60 minutes. Cash, checks, credit cards, HSA and FSA, are all accepted for services rendered, but we do not accept insurance. Payment is due on the day of service.

Arriving for your scheduled appointment

As a new patient, please plan to arrive 15 minutes prior to your scheduled appointment. This will ensure all the needed paperwork and documentation is completed prior to your appointment. The WHI providers value your time and will do everything possible to start your visit on time. This intake form **MUST** be completed and submitted **BEFORE** your scheduled appointment. If it is not completed, we may ask to reschedule your appointment.

Late Policy

You are expected to arrive 15 minutes prior to your scheduled appointment. If you are going to be 15 minutes late to your scheduled appointment time, we may request to reschedule your appointment and will be based on providers discretion and patient schedule. If you are 15 minutes late or more and are seen by the provider, you will be charged the full amount of your originally scheduled appointment, regardless of start time. If you arrive to your scheduled appointment time but have not completed and signed this intake form, we may request to reschedule your appointment.

Phone Policy

If you have a question that can be answered by a staff member, simply call the office, and ask for assistance. The staff member may consult with your WHI provider and return your call. We also encourage that each patient gets registered into the AdventHealth patient portal to communicate with the WHI providers.

Cancellation Policy

As a courtesy, phone call reminders are made whenever possible. If you must cancel, please do so 48 hours before your appointment so we can offer that appointment slot to other patients. You can call the clinic at 913-632-3550 to change or cancel an appointment. **Cancellations made less than 24 hours of the scheduled appointment time may be billed for the full appointment.**

Insurance

We do not currently file insurance for your visits. If you have a flex spending account or a health care savings account, you are encouraged to submit your visit. Your supplements may also be covered by your health care savings or flex spending account.

Labs

The WHI provider may need lab work to better understand your case. Coverage often depends upon where the labs are drawn and if they are considered medically necessary. Please look into your policy by calling your insurance company before your visit. The WHI offers many specialty lab tests, including nutritional assays, hormonal testing, digestive function testing, food allergy/intolerance testing, neurotransmitter testing, genetic testing, etc. These tests may or may not be covered by your insurance. You will need to check with your insurance to determine coverage.

You will not get specialty lab coverage through Medicare or Medicaid.

Supplements

Supplements (vitamin, minerals, herbs and homeopathy) are recommended on a case by case basis. Please be advised that we do not currently dispense supplements.

***FullScript** is a virtual supplement dispensary and a comprehensive platform that integrative healthcare professionals use to dispense the best quality supplements. The WHI providers will enroll all patients into their dispensary upon registering as a new patient and send supplement recommendations to you via the FullScript patient dashboard.

Consultations with other doctors

The WHI providers may consult with other doctors and professionals regarding your case. We encourage you to keep your primary care provider and other physicians involved in your care.

You may be contacted by phone. If you have special contact instructions, please let us know at the time of visit. For follow up questions, lab results, and other general information, you will be contacted by a member of the staff. They will consult with a WHI provider before answering your questions if needed. If you need immediate assistance, call the office, and inform a member of the staff. Phone messages are generally answered within 24 business hours. If you need to speak with someone right away, we will do everything we can to schedule an emergency visit. If that is not possible or appropriate, we may refer you to urgent care. If you have an emergency when the office is closed, please call 911.

Communications from the Whole Health Institute

As a patient of the Whole Health Institute, we want to make it easy for you to receive information on upcoming events, program offerings, articles, and/or recipes provided by your Whole Health Institute care team. By signing this document, you agree to receive email notifications that offer additional wellness resources.

**Signature needed on page 9*

I, _____ (or the patient named below for whom I am legally responsible), hereby request and consent to receive integrative and holistic medical care by a Whole Health Institute provider. I understand that the methods of treatment may include but are not limited to nutritional counseling, western herbs, stress management tools, and nutritional supplements.

The herbs, and nutritional supplements (which are from plant, animal, mineral, and other sources) that have been recommended, are considered safe when taken as instructed in the practice of integrative and holistic medicine. It is extremely important that one follow the prescribed recommendations when taking herbs and nutritional supplements because they may be toxic when taken in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding, and I will immediately notify the doctor if I become aware that I am pregnant. I will also keep my WHI provider and my other health care providers informed about all the medications, herbs and supplements I take to minimize risk of interaction.

I have read and understand these policies.

Patient/Guardian Signature _____

Printed Name _____

Date: ____/____/____