AdventHealth
Whole Health Institute

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: _____ PrimaryPhone:_____

Primary Address:

_____

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

Occupation:_____ Employer:_____

Emergency contact:_____Relationship:_____Phone:_____

How did you hear about our clinic?

_____

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.

***If you are an established patient with the Whole Health Institute and have completed our intake form within the last year, please skip to page 3.*

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

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

FAMILY HISTORY: *Family* ☐ *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 (add additional rows, if needed)	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:

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*.

LIFESTYLE

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

How often and how long?

Sleep: Duration: ☐ 8+ hours ☐ 6-8 hours ☐ <6 hours
Sleep Quality: ☐ Good ☐ Fair ☐ Poor

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

Tobacco use: ☐ No ☐ Yes

If yes, please specify: ☐ Cigarettes ☐ Vaping ☐ Chewing tobacco

Packs per day: _____ Number of years:_____

DIGESTIVE HEALTH

Digestive function: ☐ Good ☐ Fair ☐ Poor Bowel movements: ☐ Daily ☐< 1x day ☐1-2x day

Please check all that apply:

☐ Diarrhea ☐ Abdominal cramps or spasms ☐ Nausea / Vomiting
☐ Constipation ☐ Excess gas ☐ Appetite concerns
☐ Heartburn ☐ Uncomfortable fullness ☐ 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 their 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

What time do you usually eat BREAKFAST: _____

Usual breakfast foods: _____

_____

What time do you usually eat LUNCH: _____

Usual lunch foods: _____

_____

What time do you eat DINNER: _____

Usual dinner foods: _____

_____

What time do you eat SNACKS: _____

Usual snack foods: _____

_____

Servings of vegetables eaten daily? Which ones?	
Servings of fruits eaten daily? Which ones?	

What types of protein do you consume most days of the week? (Check all that apply):

☐ Animal meat ☐ Fish/Seafood ☐ Beans ☐ Eggs ☐ Nuts and seeds ☐ Protein powder

What specific proteins do you eat most frequently/daily?

What types of dairy products or plant-based dairy substitutes do you consume most days of the week? (Check all that apply)

☐ milk ☐ cheese ☐ cottage cheese ☐ cream cheese ☐ sour cream ☐ yogurt / kefir ☐ butter

☐ plant-based milk – type: ☐ other plant-based products:

What types of grains or grain products do you consume most days of the week? (Check all that apply)

☐ White bread ☐ 100% Whole Wheat Bread ☐ Gluten-free bread ☐ Sprouted grain bread

☐ Bagels ☐ Muffins ☐ Biscuits/rolls ☐ Flour tortillas ☐ Pastries, cookies, cakes

☐ Pretzels ☐ Crackers ☐ 100% Whole Grain Crackers ☐ Gluten-free crackers

☐ White pasta ☐ 100% whole wheat pasta ☐ Gluten-free pasta ☐ Breakfast cereals:_____

☐ Oats ☐ White Rice ☐ Brown rice ☐ Quinoa ☐ Polenta, Grits, Popcorn ☐ Other:

What cooking oils do you consume most days of the week? (Check all that apply) ☐Olive oil ☐ Vegetable oil (corn, soy, safflower) ☐ Avocado oil ☐ Coconut oil ☐ Other
Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, what?_____ Frequency:_____
Do you drink any alcohol? ☐ Yes ☐ No If yes, what?_____ Frequency:_____
Do you use artificial sweeteners? ☐ Yes ☐ No If yes, what?_____ Frequency:_____
Do you drink soda? ☐ Yes ☐ No If yes, what?_____ Frequency:_____
Do you drink diet soda? ☐ Yes ☐ No If yes, what?_____ Frequency:_____
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 scheduled 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. 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. 10

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 8

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 by 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: _____/_____/_____