

**Program in Integrative Medicine**

University of Kansas Medical Center  
Mail Stop 1017  
3901 Rainbow Blvd  
Kansas City, KS 66160

Lisa Markley, MS, RD, LD  
Dietitian & Nutrition Educator  
Phone 913-588-6208  
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**New Patient Registration for Nutrition Appointment (Referral)**

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

Phone # (Home): \_\_\_\_\_ (Work/Cell): \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

How do you prefer to be contacted? (please circle all that apply)      home    work    cell    email

Sex:     Female     Male      Age: \_\_\_\_\_      Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_      Marital Status: \_\_\_\_\_

Do you have any children? \_\_\_\_\_      Age of children: \_\_\_\_\_

Are you pregnant? Yes    No      If so, when are you due? \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_      Date of last physical exam: \_\_\_\_\_

Other doctors or practitioners that you see: \_\_\_\_\_

Insurance Company\* \_\_\_\_\_

Address \_\_\_\_\_

**\*WE DO NOT SUBMIT INSURANCE BUT BILLING WILL PROVIDE YOU WITH THE NECESSARY INFORMATION TO SUBMIT YOUR OWN FORMS. PLEASE CALL THE OB/GYN BILLING DEPARTMENT AT 913-588-6527 IF YOU HAVE QUESTIONS.**

Please check the nutritional services in which you are interested:

- Nutritional Counseling
- Food Shopping Tour
- Cooking Classes

Referred by: \_\_\_\_\_

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**Reason for visit/nutritional concerns:** \_\_\_\_\_  
\_\_\_\_\_

**What do you hope to get out of your visit today?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What are your nutrition and health goals?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Is there anything that holds you back from attaining your health and nutrition goals?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What, if anything, have you tried in the past to manage your nutrition related concerns?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had any new diagnoses or experienced any significant changes in your health condition or symptoms since establishing care with one of our Integrative Medicine Practitioners? If so, please describe:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Medical Symptoms Questionnaire

Name \_\_\_\_\_

Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for:

Past 30 days  Past 48 hours

### Point Scale

0 - *Never* or *almost never* have the symptom

1 - *Occasionally* have it, effect is *not severe*

2 - *Occasionally* have it, effect is *severe*

3 - *Frequently* have it, effect is *not severe*

4 - *Frequently* have it, effect is *severe*

### HEAD

\_\_\_\_\_ Headaches

\_\_\_\_\_ Faintness

\_\_\_\_\_ Dizziness

\_\_\_\_\_ Insomnia

Total \_\_\_\_\_

### EYES

\_\_\_\_\_ Watery or itchy eyes

\_\_\_\_\_ Swollen, reddened or sticky eyelids

\_\_\_\_\_ Bags or dark circles under eye

\_\_\_\_\_ Blurred or tunnel vision

(does not include near or far-sightedness)

Total \_\_\_\_\_

### EARS

\_\_\_\_\_ Itchy ears

\_\_\_\_\_ Earaches, ear infections

\_\_\_\_\_ Drainage from ear

\_\_\_\_\_ Ringing in ears, hearing loss

Total \_\_\_\_\_

### NOSE

\_\_\_\_\_ Stuffy nose

\_\_\_\_\_ Sinus problems

\_\_\_\_\_ Hay fever

\_\_\_\_\_ Sneezing attacks

\_\_\_\_\_ Excessive mucus formation

Total \_\_\_\_\_

### MOUTH/THROAT

\_\_\_\_\_ Chronic cough/homh

\_\_\_\_\_ Gagging, frequent need to clear throat

\_\_\_\_\_ Sore throat, hoarseness, loss of voice

\_\_\_\_\_ Swollen or discolored tongue, gums, lips

\_\_\_\_\_ Canker sores

Total \_\_\_\_\_

### SKIN

\_\_\_\_\_ Acne

\_\_\_\_\_ Hives, rashes, dry skin

\_\_\_\_\_ Hair loss

\_\_\_\_\_ Flushing, hot flashes

\_\_\_\_\_ Excessive sweating

Total \_\_\_\_\_

### HEART

\_\_\_\_\_ Irregular or skipped heartbeat

\_\_\_\_\_ Rapid or pounding heartbeat

\_\_\_\_\_ Chest pain

Total \_\_\_\_\_

Applying Functional Medicine in Clinical Practice

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Medical Symptoms Questionnaire

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<b>LUNGS</b>	<input type="checkbox"/> Chest congestion	
	<input type="checkbox"/> Asthma, bronchitis	
	<input type="checkbox"/> Shortness of breath	
	<input type="checkbox"/> Difficulty breathing	Total _____
<b>DIGESTIVE TRACT</b>	<input type="checkbox"/> Nausea, vomiting	
	<input type="checkbox"/> Diarrhea	
	<input type="checkbox"/> Constipation	
	<input type="checkbox"/> Bloating feeling	
	<input type="checkbox"/> Belching, passing gas	
	<input type="checkbox"/> Heartburn	
	<input type="checkbox"/> Intestinal/stomach pain	Total _____
<b>JOINT/MUSCLE</b>	<input type="checkbox"/> Pain or aches in joints	
	<input type="checkbox"/> Arthritis	
	<input type="checkbox"/> Stiffness or limitation of movement	
	<input type="checkbox"/> Pain or aches in muscles	
	<input type="checkbox"/> Feeling of weakness or tiredness	Total _____
<b>WEIGHT</b>	<input type="checkbox"/> Binge eating/drinking	
	<input type="checkbox"/> Craving certain foods	
	<input type="checkbox"/> Excessive weight	
	<input type="checkbox"/> Compulsive eating	
	<input type="checkbox"/> Water retention	
	<input type="checkbox"/> Underweight	Total _____
<b>ENERGY/ACTIVITY</b>	<input type="checkbox"/> Fatigue, sluggishness	
	<input type="checkbox"/> Apathy, lethargy	
	<input type="checkbox"/> Hyperactivity	
	<input type="checkbox"/> Restlessness	Total _____
<b>MIND</b>	<input type="checkbox"/> Poor memory	
	<input type="checkbox"/> Confusion, poor comprehension	
	<input type="checkbox"/> Poor concentration	
	<input type="checkbox"/> Poor physical coordination	
	<input type="checkbox"/> Difficulty in making decisions	
	<input type="checkbox"/> Stuttering or stammering	
	<input type="checkbox"/> Slurred speech	
	<input type="checkbox"/> Learning disabilities	Total _____
<b>EMOTIONS</b>	<input type="checkbox"/> Mood swings	
	<input type="checkbox"/> Anxiety, fear, nervousness	
	<input type="checkbox"/> Anger, irritability, aggressiveness	
	<input type="checkbox"/> Depression	Total _____
<b>OTHER</b>	<input type="checkbox"/> Frequent illness	
	<input type="checkbox"/> Frequent or urgent urination	
	<input type="checkbox"/> Genital itch or discharge	Total _____
<b>GRAND TOTAL</b>		<b>TOTAL _____</b>

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**Medications & Supplements**

**PLEASE FILL OUT THE FORM BELOW IF YOU ARE A NEW PATIENT OR IF YOUR SUPPLEMENT/  
MEDICATION REGIMEN HAS CHANGED SINCE YOUR LAST APPOINTMENT IN OUR CLINIC.**

**What medications and supplements are you taking now? Include non-prescription drugs as well as vitamins, minerals, and other nutritional supplements. Indicate the mg or IUs and the form (e.g. calcium carbonate vs. calcium lactate) when possible.**

<b>Supplements / Medications</b>	<b>Dose</b>	<b>Units</b>	<b>Frequency</b>	<b>Start Date</b>	<b>Stop Date</b>
				-- / -- / --	-- / -- / --
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**Lifestyle Habits**

Physical Activity

Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Type: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Is there anything that limits you from doing physical activity?

\_\_\_\_\_

On a scale of 1 to 10, what is your overall level of stress? (0=no stress; 10=overwhelming stress) \_\_\_\_/10

What helps you to unwind? \_\_\_\_\_

On average, how many hours of sleep do you get at night? \_\_\_\_\_

Do you smoke?  Never  In the past  Currently How long? \_\_\_\_\_

Drug use  Never  In the past  Currently  Prefer to discuss with practitioner  
Type/frequency \_\_\_\_\_

**Weight History:**

Would you like to be weighed today?  Yes  No

Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Desired Body Weight \_\_\_\_\_

Highest Adult Weight \_\_\_\_\_ When? \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Have you had any recent changes in your weight that you are concerned about?  Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**Digestion**

How many times a day do you have a bowel movement? \_\_\_\_\_

Do you take laxatives, and if you do, how often? \_\_\_\_\_

Would you describe your stools are hard, soft, or loose? (circle one)

Do you experience:

Heartburn?	Often	Sometimes	Rarely
Gas?	Often	Sometimes	Rarely
Bloating?	Often	Sometimes	Rarely
Stomach Pain?	Often	Sometimes	Rarely
Nausea/Vomiting?	Often	Sometimes	Rarely
Diarrhea?	Often	Sometimes	Rarely
Constipation?	Often	Sometimes	Rarely

Do you associate any digestive symptoms with eating certain foods?  Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_

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### Diet History

Are you following a special diet or do you have specific dietary limitations or needs based on health, ethnic, cultural, or religious preferences?  Yes  No

Please explain: \_\_\_\_\_

Please list any food allergies, sensitivities, and/or intolerances: \_\_\_\_\_

Do you prepare the majority of your meals? \_\_\_\_\_ If not, who does? \_\_\_\_\_

If yes, how much time do you spend on a daily basis preparing your meals? \_\_\_\_\_

What cooking methods do you use most often?

Fry \_\_\_\_\_ Bake \_\_\_\_\_ Grill \_\_\_\_\_ Sautee \_\_\_\_\_ Steam \_\_\_\_\_ Microwave \_\_\_\_\_

Do you find cooking difficult?  Yes  No

Please explain: \_\_\_\_\_

Are there any foods that you'd like to learn to cook or new cooking methods that you would like to try? \_\_\_\_\_

Who does the food shopping for your household? \_\_\_\_\_

Where is food shopping done? \_\_\_\_\_

Which of the following beverages do you drink and how much?:

<b>Water:</b> <input type="checkbox"/> tap <input type="checkbox"/> bottled	How much? _____ day
<b>Coffee:</b> <input type="checkbox"/> regular <input type="checkbox"/> decaf <input type="checkbox"/> latte	How much? _____ day _____ week _____ month
<b>Tea:</b> <input type="checkbox"/> regular <input type="checkbox"/> decaf <input type="checkbox"/> herbal <input type="checkbox"/> green	How much? _____ day _____ week _____ month
<b>Juice:</b> <input type="checkbox"/> natural <input type="checkbox"/> fruit drinks	How much? _____ day _____ week _____ month
<b>Soda:</b> <input type="checkbox"/> regular <input type="checkbox"/> diet	How much? _____ day _____ week _____ month
<b>Milk:</b> <input type="checkbox"/> whole <input type="checkbox"/> 2% <input type="checkbox"/> 1% <input type="checkbox"/> skim	How much? _____ day _____ week _____ month
<b>Milk alternative</b> Type: _____	How much? _____ day _____ week _____ month
<b>Alcohol:</b> <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> mixed drinks	How much? _____ day _____ week _____ month
<b>Other:</b> _____	How much? _____ day _____ week _____ month

How often do you eat:	1 time/day	2-3 times/day	2-3 times/week	1 time/week	2-3 times/month
At fast food restaurants					
Vending machine foods					
At Cafeterias or Buffets					
At full service restaurants					
Frozen Meals					
Home Cooked Meals					
Leftovers					

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How often do you eat the following foods:	1 time/day	2-3 times/day	2-3 times/week	1 time/week	2-3 times/month
Hamburger/Ground Beef					
Steak					
Liver					
Veal					
Ham					
Pork Chop/Tenderloin					
Bacon					
Lamb					
Chicken					
Turkey					
Deli meat; type:					
Fish; type:					
Soyfoods; type:					
Beans; type:					
Cereal; type:					
Bread; type:					
Crackers; type:					
Foods made with white flour Type:					
Whole Grains; type:					
Fresh/Raw Vegetables					
Cooked Vegetables					
Fruit					
Margarine					
Butter					
Cheese					
Yogurt					
Olive oil					
Vegetable oil; type:					
Mayonnaise					
Salad Dressing; type:					
French Fries					
Potato Chips					
Tortilla Chips					
Fried Chicken					
Fried Fish					
Foods with added sugars/high fructose corn syrup; type:					
Foods with hydrogenated oils/trans-fats					
Artificial Sweeteners					
Meal Replacements					

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Food cravings: \_\_\_\_\_

Food dislikes: \_\_\_\_\_

### **Eating Style**

*Please circle the answers that best describe you*

I eat while involved in other activities (watching TV, reading, writing, working, etc.)	Often	Sometimes	Rarely
I eat when I'm bored, upset, lonely, angry, anxious/worried (circle all that apply)	Often	Sometimes	Rarely
I eat past point of being full, eating to the point of discomfort	Often	Sometimes	Rarely
I consider how hungry I feel before ordering food in a restaurant or preparing a meal at home	Often	Sometimes	Rarely
I think about food excessively	Often	Sometimes	Rarely
My thoughts of food, weight or body image affect my quality of life	Often	Sometimes	Rarely
I feel guilty about food, my body, my weight or overeating	Often	Sometimes	Rarely
I skip meals or consciously restrict my calories to avoid gaining weight	Often	Sometimes	Rarely
I wait until I'm extremely hungry to eat	Often	Sometimes	Rarely
I hide the food I eat (or the amount I eat) from others	Often	Sometimes	Rarely
I head straight to the kitchen as soon as I get home	Often	Sometimes	Rarely
I eat the same foods every day	Often	Sometimes	Rarely
I feel worse after eating	Often	Sometimes	Rarely
I feel better when I don't eat	Often	Sometimes	Rarely
I feel irritable, lightheaded, low energy, nauseous or get a headache when I don't eat	Often	Sometimes	Rarely
I eat in my car	Often	Sometimes	Rarely
I eat in front of the refrigerator	Often	Sometimes	Rarely
I eat late at night	Often	Sometimes	Rarely
I eat large amounts of food very quickly	Often	Sometimes	Rarely
I will eat a second helping of food or eat dessert after a meal even if I'm not hungry	Often	Sometimes	Rarely
I crave refined carbohydrates (sugar, candy, pastries, chips, crackers, bread, pasta, etc.)	Often	Sometimes	Rarely
I use sugar and/or caffeine in foods and drinks to give me a lift if I'm low on energy	Often	Sometimes	Rarely
I consume foods/drinks that contain artificial colors	Often	Sometimes	Rarely

Which of your dietary choices or habits do you feel most challenged by?

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Which of your dietary choices or habits are you most pleased with?

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