

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

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?

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Past Medical History & Family History

Has anyone in your family, *including yourself*, grandparents, parents and siblings, been diagnosed with any of the following symptoms or conditions? If yes, please indicate who and age at which they were diagnosed.

	<u>Yourself</u>	<u>Age diagnosed</u>	<u>Relative(s) and Ages Diagnosed</u>
<input type="checkbox"/> Allergies			
<input type="checkbox"/> Alzheimer's			
<input type="checkbox"/> Anemia			
<input type="checkbox"/> Anxiety or Panic Attacks			
<input type="checkbox"/> Arthritis (please circle: osteoarthritis or rheumatoid)			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Autoimmune condition; type:			
<input type="checkbox"/> Cancer; type:			
<input type="checkbox"/> Chronic Fatigue Syndrome			
<input type="checkbox"/> Depression			
<input type="checkbox"/> Diabetes (please circle: Type I, Type II, or Prediabetes)			
<input type="checkbox"/> Dry, itching skin, rashes, or dermatitis			
<input type="checkbox"/> Eczema			
<input type="checkbox"/> Eye Disease; please name:			
<input type="checkbox"/> Fibromyalgia			
<input type="checkbox"/> Food Allergies or Sensitivities			
<input type="checkbox"/> Fungal Infection (e.g. athlete's foot, ringworm)			
<input type="checkbox"/> Gallbladder Disease			
<input type="checkbox"/> Gout			
<input type="checkbox"/> Heartburn			
<input type="checkbox"/> Heart Disease			
<input type="checkbox"/> Hepatitis			
<input type="checkbox"/> Hypoglycemia (low blood sugar)			
<input type="checkbox"/> High blood pressure (hypertension)			
<input type="checkbox"/> High cholesterol			
<input type="checkbox"/> High Triglycerides			
<input type="checkbox"/> Insulin Resistance			
<input type="checkbox"/> Intestinal Disease; type:			
<input type="checkbox"/> Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
<input type="checkbox"/> Irritable Bowel Syndrome			
<input type="checkbox"/> Kidney disease or failure			
<input type="checkbox"/> Liver disease			
<input type="checkbox"/> Lung Disease; type:			
<input type="checkbox"/> Osteoporosis			
<input type="checkbox"/> PMS			
<input type="checkbox"/> Polycystic Ovarian Syndrome			
<input type="checkbox"/> Prostate problems			
<input type="checkbox"/> Psychiatric Conditions			

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Past Medical History & Family History (continued)

Has anyone in your family, *including yourself*, grandparents, parents and siblings, been diagnosed with any of the following symptoms or conditions? If yes, please indicate who and age at which they were diagnosed.

	<u>Yourself</u>	<u>Age diagnosed</u>	<u>Relative(s) and Ages Diagnosed</u>
<input type="checkbox"/> Seizures or epilepsy			
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Thyroid issues (hypo- or hyperthyroid)			
<input type="checkbox"/> Urinary Tract Infections			
<input type="checkbox"/> Other:			

Please complete the following information as it relates to your family's health history.

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
Father					Husband/ Wife/ Partner				
Mother					Children:				
Siblings:									

Are you allergic to any medications? Yes No **Please list:** _____

Have you had any surgeries? If so, please list the type of surgery and the date.

Have you had any diagnostic studies (i.e. colonoscopy, endoscopy, etc.)? If so, please list the type of diagnostic, the result, and the date. Please provide any pertinent medical records.

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

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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 as 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 _____ Sauté _____ 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?:

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

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