THE UNIVERSITY OF KANSAS PHYSICIANS
Integrative Medicine

## Nutrition New Patient Intake Form

**General Information** **Date:**

| | | | |
|---|---|---|---|
| Name | | Preferred Name: | |
| Date of Birth | | Gender: ☐ M ☐ F | Height __'__" Weight____ |
| Genetic Background | ☐ African American<br>☐ Native American<br>☐ Mediterranean | ☐ Hispanic<br>☐ Caucasian<br>☐ Northern European | ☐ Asian<br>☐ Other *(please note)* |
| Family Status | Marital Status: M S | Do you have children: Y N | Children Ages: |
| ABO Blood Type | *(circle one)* **O A B AB** | Have you ever had a blood transfusion? **Y N** | |
| Address | | | |
| | | | |
| | | | |
| Home Phone | | Cell Phone: | |
| Work Phone | | Occupation: | |
| Fax | | | |
| Email | | | |
| Best Way to Reach? | | | |
| Primary Physician | Name: | | |
| | City: | Phone: | |
| Secondary Physician | Name: | | |
| | City: | Phone: | |
| Referred by | | | |

**Complaints/Concerns**

What do you hope to achieve in your visit?

If you had a magic wand and could erase three problems, what would they be?
(list your three main health concerns)

| | |
|---|---|
| **1** | |
| **2** | |
| **3** | |

If you had a magic wand and could erase three problems, what would they be?
(list you three main nutrition concerns)

| | |
|---|---|
| **1** | |
| **2** | |
| **3** | |

| | |
|---|---|
| When was the last time you felt well? | |

Did something trigger your change in health?

The biggest Challenge(s) to reaching my nutrition goals is/are?

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition goals…

| | |
|---|---|
| What makes you feel better? | |
| What makes you feel worse? | |
| What is the lowest body weight that you have been comfortably able to maintain for at least 2 years in your adult life, since around age 30? | |
| Notes: | |

**Readiness Assessment**

*Rate on a scale of 5 (very willing) to 1 (not willing)*

In order to improve your health, how willing are you to:

| | |
|---|---|
| Significantly modify your diet | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Take several nutritional supplements each day | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Keep a record of everything you eat each day | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Modify your lifestyle (e.g., work demands, sleep habits, exercise) | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Practice a relaxation technique | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Engage in regular exercise/physical activity | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |
| Have periodic lab tests to assess your progress | ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 |

How much on-going support and contact (e.g., telephone, e-mail) from the nutritionist would be helpful to you as you implement your personal health program?

**Allergy Information**

| | |
|---|---|
| Please list <u>food</u> allergies | |
| Please list <u>non-food</u> allergies | |
| What type of allergic symptoms do you experience? | |
| Notes: | |

**Medical History**

| | Height: | Weight: | Waist: |
|---|---|---|---|

*Please check those health conditions that your doctor has diagnosed (provide the date of onset)*

| **Gastrointestinal** | **Inflammatory/Autoimmune** |
|---|---|
| ☐ Irritable Bowel Syndrome | ☐ Chronic Fatigue Syndrome |
| ☐ Inflammatory Bowel Disease | ☐ Rheumatoid Arthritis |
| ☐ Crohn's Disease | ☐ Lupus SLE |
| ☐ Ulcerative Colitis | ☐ Poor Immune Function *(frequent infections)* |
| ☐ Gastric or Peptic Ulcer Disease | ☐ Severe Infectious Disease |
| ☐ GERD (reflux/heartburn) | ☐ Herpes-Genital |
| ☐ Celiac Disease | ☐ Multiple Chemical Sensitivities |
| ☐ Hepatitis C or Liver Disease | ☐ Gout |
| ☐ Other Digestive: | ☐ Other: |
| **Cardiovascular** | **Metabolic/Endocrine** |
| ☐ Heart Disease (heart attack) | ☐ Diabetes ☐ Type 1 or ☐ Type 2 |
| ☐ Stroke | ☐ Metabolic Syndrome (insulin resistance) |
| ☐ Elevated Cholesterol | ☐ Hypoglycemia |
| ☐ Irregular heart rate – Pacemaker | ☐ Hypothyroidism (low thyroid) |
| ☐ High Blood Pressure | ☐ Hyperthyroidism (overactive thyroid) |
| ☐ Mitral Valve Prolapse/heart murmur | ☐ Polycystic Ovarian Syndrome (PCOS) |
| ☐ Other Heart & Vascular: | ☐ Genetic Disorder: _____ |
| | ☐ Other: |
| **Respiratory** | **Musculoskeletal/Pain** |
| ☐ Asthma ☐ Bronchitis | ☐ Osteoarthritis ☐ Fibromyalgia |
| ☐ Chronic Sinusitis ☐ Emphysema | ☐ Chronic Pain ☐ Migraines |
| ☐ Pneumonia ☐ Tuberculosis | ☐ Other: |
| ☐ Sleep Apnea ☐ Other: | |

Notes:

**Medical History (continued)**

Please note any past or current injuries:

| Neurological/Mood | | Cancer |
|---|---|---|
| ☐ Depression | ☐ Bipolar Disorder | ☐ Cancer *(please describe type and treatment)* |
| ☐ Anxiety | ☐ ADD/ADHD | |
| ☐ Autism | ☐ Multiple Sclerosis | |
| ☐ Seizures | ☐ Other: | |

| **Other** (use separate sheet if necessary) | | |
|---|---|---|
| ☐ Kidney stones | ☐ Anemia | Please any other diseases or health conditions |
| ☐ Eczema | ☐ Urinary (UTIs) | |
| ☐ Psoriasis | ☐ Frequent Yeast | Have you ever had genetic testing? ☐ Y ☐ N |
| ☐ Acne | ☐ Other: | If yes, please note type and results. |

**Medications** (Please list all prescribed medications you are taking and note reason.)

| | |
|---|---|
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Name: | Reason: |
| Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N | |
| Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, Prilosec, etc.)? ☐ Y ☐ N | |
| Frequent antibiotics >3 times per year? ☐ Y ☐ N | Long term antibiotics? ☐ Y ☐ N |

**Environmental Information**

| | |
|---|---|
| Do you have known adverse food reactions or sensitivities? ☐ Y ☐ N | If yes, please describe symptoms. |
| Are you exposed regularly to any of the following? *(check all that apply)* | What is your occupation? |
| ☐ Cigarette smoke<br>☐ Auto exhaust/fumes<br>☐ Dry-cleaned clothes<br>☐ Nail polish/hair dyes<br>☐ Heavy metals<br>☐ Teflon Cookware<br>☐ Aluminum Cookware<br>☐ Perfumes<br>☐ Paint fumes<br>☐ Mold<br>☐ Pesticides<br>☐ Fertilizers<br>☐ Pet dander<br>☐ Chemicals | Please note any regular exposure to harmful chemicals/substances.<br><br>Please not any past exposure to harmful chemicals/substances. |
| Do you use any recreational drugs? If so, please note. | |

Notes:

**Lifestyle Information**

Do you engage in moderate cardiovascular physical activity at least 3 days a week, for a minimum of 20 minutes duration? (brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.)

☐ Y ☐ N

| **Activity** | **Type/Intensity** (low-moderate-high) | **# Days/Week** | **Duration** (minutes) |
|---|---|---|---|
| Stretching/Yoga | | | |
| Cardio/Aerobics | | | |
| Strength Training | | | |
| Sports or Leisure | | | |

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Med ☐ High

Note any problems that limit your physical activity.

**Lifestyle Information (continued)**

| | |
|---|---|
| Do you smoke? ☐ Y ☐ N | How many years? |
| Packs per day? | 2nd hand smoke exposure? ☐ Y ☐ N |
| Excess stress in your life? ☐ Y ☐ N | Easily handle stress? ☐ Y ☐ N |
| Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*<br>☐ Work___ ☐ Family___ ☐ Social___ ☐ Finances___ ☐ Health___ ☐ Other:___ | |
| Do you feel your life has meaning and purpose?<br>☐ Y ☐ N ☐ unsure | Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N |
| Average number of hours you sleep per night during the week? | Average number of hours you sleep per night on weekends? |
| Trouble falling asleep? ☐ Y ☐ N | Rested upon waking? ☐ Y ☐ N |
| Do you wake up during the night? ☐ Y ☐ N If yes, how many times? | |
| Note the approximate times you generally wake during the night. | |
| How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality* | |

**Family History**

Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, cancer, mental illness or addiction.

| | |
|---|---|
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Family Member: | Health Condition: |
| Genetic Disorders Known: | |

**Surgeries/Hospitalizations**

Please list any surgeries or hospitalizations (include dates and your ages if known).

**Dental History**

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N If **Y**, how many?

Do you have any ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Have you ever had an infection in your jawbone? ☐ Y ☐ N

TMJ: ☐ grinding teeth ☐ jaw clicking ☐ braces? If yes, what age ___ ☐ surgery ☐ jaw pain

Teeth: ☐ extraction? How many? _____ ☐ Which teeth are missing? (# or name)_____

**Ingestion: Nutrition History**

Have you ever had a nutrition consultation? ☐ Y ☐ N

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N

*Please describe.*

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N

*Check all that apply.*

| | | | |
|---|---|---|---|
| ☐ Low fat | ☐ Low Carb | ☐ High protein | ☐ Low sodium |
| ☐ No Gluten | ☐ Vegetarian | ☐ Vegan | ☐ Diabetic |
| ☐ No Dairy | ☐ No Wheat | ☐ Weight Loss | ☐ Other _____ |

How often to you weigh yourself?

Have you had any recent history of weight loss or weight gain? If so, please describe.

How many meals per day do you eat? How many snacks?

| | |
|---|---|
| Do you avoid any particular foods? *If yes, describe.* | |
| If you could only eat a few foods a week, what would they be? | |
| How many meals do you eat out per week? | ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ more than 5 per week |

Check all the factors that apply to your current lifestyle and eating habits:

| | |
|---|---|
| ☐ Fast eater | ☐ Family member have different tastes |
| ☐ Erratic eating patterns | ☐ Love to Eat |
| ☐ Eating too much | ☐ Eat because I have to |
| ☐ Late night eating | ☐ Have a negative relationship to food |
| ☐ Dislike healthy food | ☐ Struggle with eating issues |
| ☐ Time constraints | ☐ Emotional eater (stress, bored, etc.) |
| ☐ Travel frequently | ☐ Confused about food/nutrition |
| ☐ Do not plan meals or menus | ☐ Frequently eat fast foods |
| ☐ Rely on convenience items | ☐ Poor snack choices |

**Current Eating Habits**

Mark the meals you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Where do you obtain your food from: ☐ home prepared from whole foods ___% ☐ organic __%

☐ home prepared convenience food ___% ☐ eat out ___%

Mark how many times you eat or drink the following items <u>per week:</u>

___ Soda (regular)
___ Soda (diet)
___ Alcohol
___ Hot tea
___ Cold tea
___ Coffee (regular)
___ Coffee (decaf.)
___ Sugar in coffee
___ Coffee drinks
___ Sweetened drinks
___ Sparkling water
___ Purified water
___ Tap water
___ Fruit juice
___ Lemonade
___ Milk (cow)
___ Milk (goat)
___ Soy Milk
___ Rice Milk
___ Nut Milk
___ Herbal teas

___ Fast food
___ Candy
___ Ice cream
___ Pudding
___ Refined sugars
___ Tuna fish
___ Swordfish
___ Sushi/sashimi
___ Salmon/other fish
___ Lunch meats
___ Bacon
___ Hot dogs
___ Whole eggs
___ Red meat
___ Poultry
___ Tofu
___ Tempeh/Miso

<u>Sweeteners:</u>

___ Equal/Nutrasweet (Aspartame)
___ Splenda (sucralose)
___ Saccharin
___ Stevia/Xylitol

___ Dried fruit
___ Canned fruit
___ Fresh Fruit
___ Jelly/jam
___ Sweets (cookies)
___ Green Salads
___ Raw veggies
What kind?

___ Cooked veggies
What kind?

___ Potatoes
___ Yams/Sweet Potatoes
___ Popcorn
___ Cereals
___ Oatmeal
___ Bagels/pretzels
___ White bread
___ Sprouted Br.
___ Wheat Bread

___ Crackers
___ Pasta
___ Brown rice
___ White rice
___ Corn tortillas
___ Flour tortillas
___ Potato Chips
___ Tortilla Chips
___ Pizza
___Yogurt (plain)
___ Yogurt (sweet)
___ Prepared meals (Lean cuisine, etc.)
___ Microwave meals/soups
___ Restaurant meals (healthy)
___ Restaurant meals (unhealthy)
___ Airplane meals
___ Legumes (beans, lentils)

**Notes:**

**Ingestion: Nutrition History (continued)**

| | |
|---|---|
| What are the top three dietary changes do you think would make the most difference in your overall health? | **1.**<br>**2.**<br>**3.** |
| How committed are you to making dietary changes in order to improve your health? | *not committed* **1 2 3 4 5** *very committed* |

Please list all nutritional supplements you currently take daily. Please include brand names and amounts as well as any herbs/botanical products.

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N If yes, # daily?

Do you use artificial sweeteners? ☐ Y ☐ N If yes, which ones?

**Digestion:**

Do you feel like belching or are you bloated after eating? ☐ Y ☐ N

Do you have (or had) any eating disorders? ☐ Y ☐ N If yes, please describe.

Bowel Movements: How often? _____ Color? _____ Consistency? _____

| | |
|---|---|
| Your Birth: ☐ Natural/vaginal ☐ C-Section | Were you breastfed as an infant (if known)? ☐ Y ☐ N |

Please note anything additional about your nutrition/eating habits.