Whole Health Institute Intake Form

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. This form must be completed prior to your first appointment and can be faxed to 913-632-3559 or securely emailed to SOP.WholeHealthInstitute@AdventHealth.com.

*To reschedule or cancel your appointment, call **913-632-3550**.*

**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. If you arrive to your scheduled appointment time, but do not have completed and signed documents for your provider, we may request to reschedule your appointment.

First Name: _____

Middle Initial: _____ Last Name: _____

Parent/Guardian, if applicable:

_____

Address:_____ City: _____ State: _____

ZIP: _____

Cell Phone:(_____) _____-_____

Birth Date: _____ /_____/_____ Age: _____

Preferred Phone:(_____) _____-_____

Occupation: _____

Today's Date: _____ /_____/_____ Email: _____

☐ **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.

How did you hear about us? (If another person, please provide name)

_____

Please List any other Medical Providers:

Type of Medical Provider	Name	Phone #	City, State
Primary Care Physician			

Current Insurance Provider: _____

Health Priorities/ Chief Concerns

List your main health concerns (or reasons for visiting the clinic) in order of importance:

1. _____
2. _____
3. _____
4. _____

Medical History

Medical Condition/ Surgeries/Hospitalizations	Date of Diagnosis	Is the condition still present?	Symptoms

Drug allergies or Food sensitivities:

Please indicate any allergies and/or serious food sensitivities

Allergy/Sensitivity	Severity	Allergy/Sensitivity	Severity

Medications/Supplements:

Please list all current medications/supplements

Medication/ Supplement	Dose (if known)/ Length of use	Prescribing Physician	Condition it is treating

Past Medications/Supplements:

Please list all past medications/supplements in the last 5 years

Medication/ Supplement	Dose (if known)/ Length of use	Prescribing Physician	Condition it is treating

Do you use/have any of the following?

Substance	Circle One	How often/How much/What brand/Type
Alcohol	Yes ☐ No ☐	
Cigarettes/chewing tobacco	Yes ☐ No ☐	
Recreational Drugs	Yes ☐ No ☐	
Aspirin/Ibuprofen	Yes ☐ No ☐	
Laxatives	Yes ☐ No ☐	
Anti-acids	Yes ☐ No ☐	
Diet Pills	Yes ☐ No ☐	
Coffee	Yes ☐ No ☐	
Black Tea/Green Tea	Yes ☐ No ☐	

Soda/Diet Soda	Yes ☐ No ☐	
Birth Control Pills	Yes ☐ No ☐	
Energy drinks	Yes ☐ No ☐	

Screening Tests:

Please indicate which of the following screening tests do you receive (if known)

Test	Circle One	How often
PAP Test (women)	Yes ☐ No ☐ Never ☐	
Breast Exam (women)	Yes ☐ No ☐ Never ☐	
Mammogram (women)	Yes ☐ No ☐ Never ☐	
DEXA scan	Yes ☐ No ☐ Never ☐	
PSA test (men)	Yes ☐ No ☐ Never ☐	
Cholesterol	Yes ☐ No ☐ Never ☐	
Blood glucose	Yes ☐ No ☐ Never ☐	
CBC (complete blood count)	Yes ☐ No ☐ Never ☐	
Colonoscopy	Yes ☐ No ☐ Never ☐	
EGD/upper endoscopy	Yes ☐ No ☐ Never ☐	

Family History:

Illness	Circle One	Family Member	Complications/Severity
Allergies	Yes ☐ No ☐		
Asthma	Yes ☐ No ☐		
Diabetes	Yes ☐ No ☐		
Heart Disease	Yes ☐ No ☐		
Cancer	Yes ☐ No ☐		
Depression	Yes ☐ No ☐		
Other mental illness	Yes ☐ No ☐		
Autoimmune Disease	Yes ☐ No ☐		
Infertility	Yes ☐ No ☐		
Digestive complaints	Yes ☐ No ☐		
High blood pressure	Yes ☐ No ☐		
Other	Yes ☐ No ☐		
Family History Unknown	Yes ☐ No ☐		

Female:

Are you currently or could be pregnant: Y☐ | N ☐Date of last menstrual period: _____

Have you ever been pregnant? Y☐ | N☐How many times: ___ How many vaginal births: _____
C-Sections: _____ Miscarriages: _____

Have your periods been regular: Y ☐ | N☐ Infertility History? Y ☐ | N ☐

Birth control methods used in the past: _____
Current birth control method: _____

Are you currently (circleone):
Pre-menopausal☐ | Transitioning through menopause☐ | Post-menopausal ☐

Have you/are you, taking HRT: Y☐ | N☐How long: _____

Lifestyle:

Do you have a strong emotional support network: Y☐ | N☐

How would you currently rateyour level of stress at this time?
Minimal ☐ | Average ☐ | Considerable ☐ | Unbearable ☐

What are the major causes of stress in your life at this time: (check all that apply):
Financial☐ | Career☐ | Personal☐ | Marriage/Relationship☐ | Health☐ | Family ☐ | Spiritual☐ | Other ☐

How does your stress manifest itself? _____

What type of coping mechanism do you employ to manage your stress?
_____

What do you do for exercise/movement? (indicate type, frequency and time of day):
_____
How many hours per night do you sleep: _____ Nap: _____

Do you wake rested in the morning: Y☐ | N☐

Are you satisfied with your sleep/sleep habits?
_____

Do you enjoy your work: Y☐| N☐| Sometimes☐When was your last vacation? _____

Do you actively participate in a spiritual discipline (church, synagogue, meditation, etc..) Y☐| N☐

Dietary Habits:

How do you think you could improve your diet?

_____

_____

Please provide examples of the following:

Breakfast:_____

Snack:_____

Lunch:_____

Snack:_____

Dinner:_____

	Do you eat: Yes I Sometimes I No	**How often:** Daily | Weekly | Monthly
Red Meats; cold cuts, bacon, hot dogs		
Processed Foods		
Candy		
Dairy Products; milk, cheese, butter		
Soda		
Nuts & Seeds		
Lentils & Beans		
Fish & Seafood		
Fruit		
Vegetables		

Digestion:

Do you have regular bowel movements: Y☐ N☐Do you regularly have loose stools: Y☐ N☐

Do you associate digestive difficulties with any particular foods: Y☐ N☐

Which foods: _____ History of Constipation? Y☐ N☐

How many bowel movements do you have per week on average? 7+☐ 4-5☐ less than 3☐

Any history of digestive concerns? _____

How many times have you taken antibiotics within the last 5 years? _____

Were you frequently given antibiotics as a child? _____

What conditions did you need antibiotics for? _____

Review of Systems

Please list conditions or concerns that involve the following systems:

SKIN (eg. Eczema, psoriasis, hives, rashes, dry skin, hair loss)

_____

HEAD (eg. Headaches)

_____

EYES (eg. Itching, pain, infection, dry eye)

_____

EARS (eg. Wax, discharge, hearing impairment, itchy)

_____

NOSE (eg. Sinus problems, pain, nose bleeds)

_____

MOUTH (eg. Cavities, loss of taste, swallowing, canker sores)

_____

NECK (eg. Tenderness, swelling)

_____

HEART (eg. Murmurs, chest pain, abnormal blood pressures)

_____

LUNGS (eg. Cough, asthma, wheezing)

_____

GASTROINTESTINAL (eg. Vomiting, swallowing, diarrhea, constipation)

_____

URINARY (eg. Pain, increased frequency, incontinence)

_____

FEMALE (eg. Urgency, discharge, pain or masses)

_____

MUSCLE AND BONES (eg. Joint pain, stiffness, back pain)

_____

NEUROLOGICAL (eg. Seizures, memory, vision, speech)

_____

BEHAVIORAL HEALTH (eg. Anxiety, Depression, OCD, AHDH)

_____

Reviewed with patient during visit on _____/_____/_____

Signed _____

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 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.

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.

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*Signature needed on next page

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: _____/_____/_____