Welcome to Atma Clinic

Congratulations on taking the first steps towards healing and optimal wellness! We are excited to journey alongside you as we work together to help you achieve your personal health goals.

Communication:

- Excellent communication is part of excellent care. Please feel free to call, text or send us a message through your patient portal any time with any need. Lawrence office hours are Monday - Friday 8am-4pm. Overland Park office hours are Monday - Thursday, 8am-4pm. Calls received after these times will be returned on the next business day. Please leave a message. If a message is not left, your call will not be returned. If you have a more pressing need please send a detailed text message or email outlining your symptoms, concerns and questions. This will ensure we get adequate details to provide the appropriate response. You may also send your provider a direct message through your patient portal.
- **Atma clinic Lawrence phone number: 785-760-0695 email**: admin@atmaclinic.com
- **Atma clinic OP phone number: 913-568-0608 email:** info@atmaclinic.com
- For pressing medical needs outside office hours please use the nurse line: 785-764-4050.
- Administrative issues may not be returned on weekends. However, all clinical issues should be returned in a timely manner. **We will answer phone calls within 24 hours**. We will answer any **patient portal messages or emails within 48 hours. If you do not hear back from us within these times, please contact us again**. If you still feel as if you are having difficulty getting a timely response please contact our clinic manager Sydney Georgie.
- Atma Clinic is committed to providing a safe, secure and respectful environment for our patients and staff. Any words or actions that are threatening or demeaning will not be tolerated and decisive actions taken to protect our patients and staff. Please notify Sydney Georgie or Crystal Olmsted immediately with concerns.

Emergency Care Policy:

- Atma Clinic does not provide Emergency Services. **If you have a medical emergency call 911 and report to your nearest Emergency Room.** Similarly, we do not provide urgent care services. We cannot be responsible for any delays in care. Please contact the office once the situation has stabilized so that your provider can coordinate with the Emergency Room or Urgent Care staff as necessary.

Appointment setting:

- When you need to schedule an appointment you may call, text or, go to the patient portal to request an appointment. At each appointment you will go through a routine doctor's office check-in. We will get blood pressure, pulse, review medical history and medications along with collecting any due payments.

Appointment Cancellations:

- It is your responsibility to notify us at least 24 business hours in advance Monday thru Saturday if you need to cancel your appointment. **Missed appointments and late cancellations will be billed at the standard appointment rate.**

Clinic Closure:

- We may cancel your appointment for inclement weather, or in the event of severe illness of your provider. Typically, we will close the clinic if there are icy conditions significant enough to create school closures or trigger other government notices. We will notify you as soon as the decision is made. If you have any questions about the adequacy of conditions on a given day, please call your rendering providers office to confirm your appointment.

Lab protocol:

- Lab appointments are scheduled Monday-Friday mornings. For most labs you will need to be fasting. This means nothing to eat or drink besides water 10-12 hours prior to your appointment time. Please remember that it is fine to drink water and we encourage you to do so up until your appointment.
- Most blood work can be drawn by our staff in our office. Some blood work can be drawn elsewhere, if you desire. However, some specialty labs MUST be drawn in our office. **Please note that there is a $25 venipuncture fee associated with in-house lab draws**. We do our best to schedule all draws in the same appointment to ensure that no more than one fee is applied.
- **Atma Clinic does not bill insurance for routine lab draws**. We have negotiated discounted prices with Labcorp for routine labs which you have access to with your membership.

Supplements:

- There is a good chance that your plan will include a combination of herbs and supplements. We use an online dispensary called Full Scripts for prescribing. Once we have implemented your plan, you will receive an email with a link to your prescribed supplements. If at any time you are unable to login to your Full Scripts account or have any questions about a supplement, please give us a call. If you are able to find the exact prescribed supplement elsewhere for less cost please feel free to purchase it. If you get onto Full Scripts to re-order and your supplement is no longer available or on back stock please give our office a call so that we can send you an alternative.

Financial Policy:

- **Payment is due at the time of service.** In certain cases, a payment plan may be offered. If a payment plan is arranged, it is your responsibility to ensure that the card on file remains active and to promptly update us with any changes to your payment information. Please note that a failed charge may incur a service fee of $25.

Neela Sandal, MD
Lauren Poull, MD
Conner Keyeski, APRN, FNP-C
Susan Dreger, APRN, FNP-C
Lisa Cason, APRN
David Lovely, LMAC, LPC, ACHt
Ashley Combs, BSND

General Information

Today's Date _____

Name _____ Age ____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell)_____ Email _____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other _____

When, where and from whom did you last receive medical or health care? _____

_____

Emergency Contact _____ Relationship _____

Phone (Home) _____ (Cell) _____ (Work) _____

How did you hear about our practice? _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Prescription Medications

Name of Medication	*Dosage/Strength*	*Directions*

Current Supplements

Name of Supplements (including brand name)	*Dosage/Strength*	*Directions*

Allergies

Name of Medication/Supplement/Food	*Reaction*

Surgical History

Type	*Date*	*Comments*
Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Hysterectomy		
Other:		
Other:		

Hospitalizations

Date	*Reason*

Diagnostic Studies

	Date	*Comments*
Bone Density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Other:		

Family History

Please check below if any blood relatives have any of the following:

	Relationship		*Relationship*
▢ Cancer		▢ Depression	
▢ Heart disease		▢ Asthma	
▢ Hypertension		▢ Allergies	
▢ Obesity		▢ Eczema	
▢ Diabetes		▢ ADHD	
▢ Stroke		▢ Autism	
▢ Autoimmune disease		▢ Irritable Bowel Syndrome	
▢ Arthritis		▢ Dementia	
▢ Kidney disease		▢ Substance abuse	
▢ Thyroid problems		▢ Genetic disorders	
▢ Seizures/Epilepsy		▢ Other: _____	
▢ Psychiatric disorder		▢ Other: _____	
▢ Anxiety		▢ Other: _____	

History

Patient's Birth/Childhood History:

You were born: ▢ Term ▢ Premature ▢ Unknown

Were there any pregnancy or birth complications? ▢ Yes ▢ No ▢ Unknown

If yes, explain: _____

You were: ▢ Breast-fed/ How long? _____ ▢ Bottle-fed/type of formula?_____ ▢ Unknown

Age of introduction of: Solid food _____ Wheat _____ Dairy _____

Did you eat a lot of sugar or candy as a child? ▢ Yes ▢ No

As a child, were there any foods that were avoided because they gave you symptoms? ▢Yes ▢No ▢Unknown

If yes, what foods and what symptoms? (example: Milk - gas and diarrhea) _____

_____

_____

What were your eating habits like as a child? (List types of food) _____

_____

_____

Dental History:

Check if you have any of the following, and provide number if applicable:

▢ Silver mercury fillings _____ ▢ Gold fillings _____ ▢ Root Canals _____ ▢ Implants_____

▢ Caps/Crowns _____ ▢ Tooth pain _____ ▢ Bleeding Gums _____ ▢ Gingivitis _____

▢ Problems with chewing _____ ▢ Other dental concerns (explain): _____

Have you had any mercury fillings removed? ▢ Yes ▢ No

If yes, when and how many _____

How many fillings did you have as a kid? _____

Do you brush regularly? ▢ Yes ▢ No Do you floss regularly? ▢ Yes ▢ No

Environmental/Detoxification History:

Do any of these significantly affect you?

▢ Cigarette smoke ▢ Perfume/Colognes ▢ Auto exhaust fumes ▢ Other _____

In your work or home environment are you regularly exposed to: (*Check all that apply)*

▢ Mold ▢ Water leaks ▢ Renovations ▢ Chemicals ▢ Electromagnetic radiation ▢ Damp environments

▢ Carpets or rugs ▢ Old paint ▢ Stagnant or stuffy air ▢ Smokers ▢ Pesticides ▢ Herbicides ▢ Paint

▢ Harsh chemicals *(solvents, glues, gas,acids, etc)* ▢ Cleaning chemicals ▢ Airplane Travel

▢ Heavy metals *(lead, mercury, etc.)* ▢ Plastic Food storage ▢ Other_____

Have you had a significant exposure to any harmful chemicals? ▢ Yes ▢ No

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? ▢ Yes ▢ No

If yes, do they live: ▢ Inside ▢ Outside ▢ Both inside and outside

Do you use cosmetics? ▢ Yes ▢ No

If yes, which types and brands: _____

_____

Sex History: *(complete applicable questions)*

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles _____

Cramping? ▢ Yes ▢ No Pain? ▢ Yes ▢ No

Have you ever had premenstrual problems (*bloating, breast tenderness, irritability, etc.*)? ▢ Yes ▢ No

If yes, please describe: _____

_____

Do you have other problems with your periods (*heavy, irregular, spotting, skipping, etc)*? ▢ Yes ▢ No

If yes, please describe: _____

_____

Use of hormonal birth control: ▢ Birth Control Pills ▢ Patch ▢ Nuvaring ▢ IUD

▢ Other _____ How long? _____

Any problems with hormonal birth control? ▢ Yes ▢ No

If yes, explain _____

Use of other contraception? ▢ Yes ▢ No ▢ Condoms ▢ Diaphragm ▢ Partner vasectomy ▢ Other_____

Are you in menopause? ▢ Yes ▢ No If yes, age at last period _____

Was it surgical menopause? ▢ Yes ▢ No If yes, explain surgery _____

_____

Do you currently have symptomatic problems with menopause? (*Check all that apply)*

▢ Hot flashes ▢ Mood swings ▢ Concentration/memory problems ▢ Headaches ▢ Joint pain ▢Weight gain

▢ Vaginal dryness ▢ Decreased libido ▢ Loss of control of urine ▢ Palpitations

Are you on hormone replacement therapy? ▢ Yes ▢ No

If yes, for how long and for what reason (hot flashes, osteoporosis, prevention, etc.)? _____

_____

Do you or have you ever had any sexually transmitted disease? ▢ Yes ▢ No

If yes, describe _____

Other Urogenital Symptoms: *(Check all that apply)*

▢ Endometriosis ▢ Infertility ▢ Fibrocystic breasts ▢ Vaginal infection ▢ Fibroids ▢ Ovarian cysts ▢ Pelvic inflammatory disease ▢ Reproductive Cancer ▢ Testicular Mass ▢ Testicular pain ▢ Prostate enlargement ▢ Prostate infection ▢ Change in sex drive ▢ Impotence ▢ Premature ejaculation ▢ Difficulty obtaining an erection ▢ Difficulty maintaining an erection ▢ Loss of control of urine ▢ Urinary urgency/hesitancy/change in stream ▢ Vasectomy

▢ Nocturia (urination at night) # of times per night _____

Screenings/Procedures (*If applicable, provide date)*

Last pap test: _____ ▢ Normal ▢ Abnormal

Last mammogram: _____ ▢ Normal ▢ Abnormal

Last bone density: _____ Results: ▢ High ▢ Low ▢ With Normal Range

Last PSA test: _____ PSA Levels: ▢ 0-2 ▢ 2-4 ▢ 4-10 ▢ >10

Other tests/procedures (list type and date) _____

_____

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ▢ Yes ▢ No Staying asleep? ▢ Yes ▢ No

Do you have problems with insomnia? ▢ Yes ▢ No Do you snore? ▢ Yes ▢ No

Do you feel rested upon awakening? ▢ Yes ▢ No

Do you use sleeping aids? ▢ Yes ▢ No

If yes, explain: _____

Do you wake up during the night? ▢ Yes ▢ No

If yes, what time(s)? _____

What time do you go to bed? _____ What time do you typically wake-up? _____

Exercise

Do you feel motivated to exercise? ▢ Yes ▢ A little ▢ No

Are there any problems that limit exercise? ▢ Yes ▢ No

If yes, explain _____

Do you feel unusually fatigued or sore after exercise? ▢ Yes ▢ No

If yes, explain _____

Current Exercise Program:

Cardio/Aerobic:

Type:_____

(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

Strength/Resistance:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

Flexibility/Stretching:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(check all that apply)*

▢ Vegetarian ▢ Vegan ▢ Allergy ▢ Elimination ▢ Low Fat ▢ Low Carb ▢ High Protein ▢ No Dairy

▢ Low Sodium ▢ No Wheat ▢ Gluten Free ▢ Blood Type _____ ▢ Other: _____

Do you have sensitivities to certain foods? ▢ Yes ▢ No

If yes, list food and symptoms: _____

_____

Do you have an aversion to certain foods or textures? ▢ Yes ▢ No

If yes, explain: _____

Do you adversely react to: (*check all that apply)*

▢ Monosodium glutamate (MSG) ▢ Artificial sweeteners ▢ Garlic/onion ▢ Cheese ▢ Citrus Foods

▢ Chocolate ▢ Alcohol ▢ Red Wine ▢ Sulfite-containing foods (wine, dried fruit, salad bars)

▢ Preservatives ▢ Food colorings ▢ Other food substances _____

Are there any foods that you crave or binge on? ▢ Yes ▢ No

If yes, what foods? _____

Do you crave sugar? ▢ Yes ▢ No Do you crave salt? ▢ Yes ▢ No

Do you eat 3 meals a day? ▢ Yes ▢ No If no, how many: _____

Does skipping a meal greatly affect you? ▢ Yes ▢ No

How many meals do you eat out per week? ▢ 0-1 ▢ 1-3 ▢ 3-5 ▢ >5 meals per week

How many meals are home cooked per week? ▢ 0-1 ▢ 1-3 ▢ 3-5 ▢ >5 meals per week

What are the three worst foods you eat each week? _____

_____

What are the three healthiest foods you eat each week? _____

_____

Do you feel tired, bloated and/or gassy after meals? ▢ Yes ▢ No

If yes, please explain _____

_____

Do you feel excessively hungry? ▢ Yes ▢ No

If yes, please explain _____

Do you have a poor appetite? ▢ Yes ▢ No

If yes, please explain _____

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

▢ Fast eater ▢ Eat too much ▢ Late-night eating ▢ Dislike healthy foods ▢ Time constraints

▢ Travel frequently ▢ Eat more than 50% of meals away from home ▢ Poor snack choices

▢ Health foods not readily available ▢ Significant other or family members don't like healthy foods

▢ Significant other or family members have special dietary needs ▢ Eat because I have to ▢ Love to eat

▢ Have a negative relationship to food ▢ Struggle with eating issues ▢ Don't care to cook

▢ Emotional eater (eat when sad, longley, bored, etc) ▢ Confused about nutrition advice

▢ Eat too much under stress ▢ Eat too little under stress ▢ Multitask during meals

How many servings do you eat in a typical day of these foods:

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Red meat _____ Legumes (beans, peas, etc) _____

Nuts & Seeds _____ Dairy/Alternatives _____

Fish _____ Cans of soda (regular or diet) _____

Sweets (candy, cookies, cake, ice cream, etc) _____

How many ounces of water do you drink daily? _____ oz/day

Do you drink caffeinated beverages? ▢ Yes ▢ No If yes, check amounts:

Coffee (ounces per day) _____ oz/day Tea (ounces per day) _____ oz/day

Caffeinated sodas - regular or diet (cans per day) ▢ 1 ▢ 2-4 ▢ >4

Do you have adverse reactions to caffeine? ▢ Yes ▢ No

If yes, explain: _____

When you drink caffeine do you feel : ▢ Irritable ▢ Wired ▢ Aches or pains

Tobacco Use

Do you smoke currently? ▢ Yes ▢ No # packs per day _____ # of years _____

What type? ▢ Cigarettes ▢ Smokeless ▢ Pipe ▢ Cigar ▢ Vape

Have you attempted to quit? ▢ Yes ▢ No

If yes, using what methods: _____

If you smoked previously: # packs per day _____ # of years _____

Are you regularly exposed to second-hand smoke? ▢ Yes ▢ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 oz of wine, 12 oz of beer, 1.5 oz of spirits)*

▢ 1-3 ▢ 4-6 ▢ 7-10 ▢ >10 ▢ None

Previous alcohol intake? ▢ Yes (▢ Mild ▢ Moderate ▢ High) ▢ None

Have you ever had a problem with alcohol? ▢ Yes ▢ No

If yes, please explain _____

_____

Have you ever thought about getting help to control or stop your drinking? ▢ Yes ▢ No

Other Substances

Are you currently using any recreational drugs? ▢ Yes ▢ No

If yes, type and frequency: _____

_____

Have you ever used IV or inhaled recreational drugs? ▢ Yes ▢ No

Stress

Do you feel you have an excessive amount of stress in your life? ▢ Yes ▢ No

Do you feel you can easily handle the stress in your life? ▢ Yes ▢ No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being the highest)*

Work _____ Family _____ Social _____ Finances _____ Health _____

Do you use relaxation techniques? ▢ Yes ▢ No If yes, how often? _____

Which techniques do you use? *(check all that apply)*

▢ Meditation ▢ Breathing ▢ Tai Chi ▢ Yoga ▢ Prayer ▢ Other: _____

Have you ever sought counseling? ▢ Yes ▢ No Are you currently in therapy? ▢ Yes ▢ No

If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced significant trauma? ▢ Yes ▢ No

What lifts your spirits and gives you strength? _____

_____

_____

What is the most pleasing aspect of your life right now? _____

_____

_____

What is the most unsatisfactory part of your life? _____

_____

_____

How much responsibility do you assume for the pleasing and unsatisfactory aspects of your life? _____

_____

_____

What is the best thing that could happen to you as a result of our experience working together? _____

_____

_____

What is the worst thing that could happen? _____

_____

_____

What do you like most about your life? _____

_____

_____

What do you like least about your life? _____

_____

_____

How do your health concerns make you feel imbalanced?

Mentally: _____

_____

_____

Emotionally: _____

_____

_____

Physically: _____

_____

_____

Spiritually: _____

_____

_____

Relationships

Marital status: ▢ Single ▢ Married ▢ Divorced ▢ Long-Term Partner ▢ Widow/er

With whom do you live? (*Include children, parents, relatives,friends, pets)* _____

_____

_____

Current occupation: _____

Previous occupation: _____

Do you have resources for emotional support? ▢ Yes ▢ No *(Check all that apply)*

▢ Spouse/Partner ▢ Family ▢ Friends ▢ Religious/Spiritual ▢ Pets ▢ Other _____

Do you have a religious or spiritual practice? ▢ Yes ▢ No

If yes, what kinds? _____

How important are spiritual matters to you? _____

_____

_____

Would you like your spiritual/religious beliefs to be included in our work? If yes, how much? _____

_____

_____

How well have things been going for you? (Mark on scale of 1-10, or N/A if not applicable)

	N/A	Poorly					Fine				Very Well
Overall	▢	1	2	3	4	5	6	7	8	9	10
At school	▢	1	2	3	4	5	6	7	8	9	10
In your job	▢	1	2	3	4	5	6	7	8	9	10
In your social life	▢	1	2	3	4	5	6	7	8	9	10
With close friends	▢	1	2	3	4	5	6	7	8	9	10
With sex	▢	1	2	3	4	5	6	7	8	9	10
With your attitude	▢	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	▢	1	2	3	4	5	6	7	8	9	10
With your children	▢	1	2	3	4	5	6	7	8	9	10
With your parents	▢	1	2	3	4	5	6	7	8	9	10
With your spouse	▢	1	2	3	4	5	6	7	8	9	10

Health Goals

What results or outcome do you hope to achieve from working together? _____

_____

_____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

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 every you eat each day	5	4	3	2	1
Modify your lifestyle *(e.g., work demands, sleep habits)*	5	4	3	2	1
Practice a relaxation technique	5	4	3	2	1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities? 5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to you implementing the above changes? 5 4 3 2 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email, correspondence) from our professional staff would be helpful to you as you implement your personal health program? 5 4 3 2 1

Comments _____

_____

** Please include age/year of onset in space next to condition **

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

**** If symptoms present longer than 6 months, please include age/year of onset in space next to condition ****

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Prostate enlargement	☐	☐	☐
Prostate infection	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal spasms	☐	☐	☐
Bad teeth	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of:	☐	☐	☐
Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
Bloating after meals	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
(yellow eyes or skin)			

Digestion *(cont.)*	Mild	Moderate	Severe
Lower abdominal pain			
Mucus in stools			
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:	☐	☐	☐
Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐
Ears get red	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐
Male Reproductive			
Discharge from penis	☐	☐	☐
Ejaculation problem	☐	☐	☐
Genital pain	☐	☐	☐
Impotence	☐	☐	☐
Infection	☐	☐	☐
Lumps in testicles	☐	☐	☐
Poor libido (low sex drive)	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐

Atma
REDISCOVER YOUR HEALTH

FOOD JOURNAL

NAME: _____

DOB: _____

Write down everything you eat and drink for three days, including all snacks, beverages, and water. Please include approximate amounts. If you notice any mood or digestive changes associated with a meal/snack, record it. At the bottom please record all bowel movements along with stool type.

DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time:_____)			
Snack (Time:_____)			
Lunch (Time:_____)			
Snack (Time:_____)			
Dinner (Time:_____)			
Snack (Time:_____)			

Bowel Movements (Time and Type)

Atma
REDISCOVER YOUR HEALTH

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Bowel Movements (Time and Type)

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DATE:	Beverages	Environment	Mood/Digestive Changes
Breakfast (Time:_____)			
Snack (Time:_____)			
Lunch (Time:_____)			
Snack (Time:_____)			
Dinner (Time:_____)			
Snack (Time:_____)			

Bowel Movements (Time and Type)

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

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 eyes
_____ 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 coughing
_____ 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 _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/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 _____

An Integrative approach to Personalized Medicine

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ Date of Birth _____
Address_____
City, ST, Zip _____ Phone _____

I authorize to release medical records:

From: Dr's Name/Facility Name _____
Address _____
City, ST, Zip _____
Phone _____ Fax _____

To: Atma Clinic
1011 Westdale Rd
Lawrence, KS 66049
Ph: 785-760-0695 Fax: 855-892-4307

I authorize the disclosure of the following:

( ) Progress Notes ( ) Lab
( ) Radiology and Imaging reports ( ) Immunizations
( ) Entire records ( ) Records from (date) _____ to _____
( ) Other _____

Purpose of Transfer _____

- I understand that the information in my health record may include that relation to alcohol or drug abuse, abortion, acquired immune deficiency syndrome (AIDS), developmental disabilities, human immunodeficiency virus (HIV), behavioral or mental health services, or sexually transmitted infection.
- I understand that I have the right to inspect or copy the information I have authorized to be used or disclosed by tis form.
- I understand that if the parties listed above are not health care providers, health plans or health care clearinghouses who must follow the federal standards and may be redisclosed without obtaining my authorization.
- I understand that I have the right to revoke this authorization at any time. Such revocation must be in writing and presented to address above. Such revocation will not apply to information that has already been released per this authorization.
- I understand that authorizing the disclosure of this information is voluntary. Refusing to sign this authorization will not affect my receiving treatment. It is expressly agreed that a photocopy of this authorization is as valid as the original

Signature of Patient or Legal Guardian _____
Today's Date _____ Expiration Date_____

HIPAA RELEASE FORM

Patient Name: _____ DOB: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name. (Including a spouse or significant other).

Please print name, relationship, and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

_____
Patient printed name

_____ _____
Patient signature Date

Main Office
1011 Westdale Road
Lawrence, KS 66049
785-760-0695
admin@atmaclinic.com | atmaclinic.com

Overland Park Office
10590 Barkley St, Suite 202
Overland Park, KS 66212
913-568-0308
info@atmaclinic.com | atmaclinic.com

NUTRITIONAL THERAPY
INFORMED CONSENT AND DISCLAIMER

Before you choose to use the services of a Nutritional Therapist, please read the following information **FULLY AND CAREFULLY.**

GOAL: Our basic goal is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimum level. Nutritional therapy is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A Nutritional Therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. A Nutritional Therapist is not trained to provide medical diagnoses, and no comment or recommendation should be construed as being a medical diagnosis. Since every human being is unique, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you need to consult with an appropriate healthcare provider. A Nutritional Therapist is not a substitute for your family physician or other appropriate healthcare provider. A Nutritional Therapist is not trained nor licensed to diagnose or treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of another healthcare provider, it is important that you contact your other healthcare providers and alert them to your use of nutritional supplements. Nutritional therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important you always keep your physician informed of changes in your nutritional program.

If you are using medications of any kind, you are required to alert the Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist.

If you have any physical or emotional reaction to nutritional therapy, discontinue their use immediately, and contact your Nutritional Therapist to ascertain if the reaction is adverse or an indication of the natural course of the body's adjustment to the therapy.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. It is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to do your part by using your nutrition guidelines, exercise your body and mind sufficiently to bring your emotions into a positive balance, eat a proper diet, get plenty of rest, and learn about nutrition. You must stay in contact with the Nutritional Therapist so we can let you know what is happening and the best course of action.

You should request your other healthcare provider, if any, to feel free to contact the Nutritional Therapist for answers to any questions they may have regarding nutritional therapy.

LICENSURE: A Nutritional Therapist is not licensed or certified by any state. However, a Nutritional Therapy Practitioner™ is trained by the Nutritional Therapy Association, Inc.® which provides a certificate of completion to students who have successfully met all course requirements, including a written and practical exam. A license to practice Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

FEES: This coaching agreement is valid as of date of signing. Client agrees to pay all fees at time of visit. Fees are per visit, in accordance with fee schedule. The fee schedule is subject to change upon notice from Atma Clinic to Client.

CANCELLATION POLICY: Client agrees that it is the Client's responsibility to notify the Nutrition Therapist 24 hours in advance of the scheduled calls/meetings. Nutrition Therapist reserves the right to bill Client for a missed meeting. Nutrition Therapist will attempt in good faith to reschedule the missed meeting.

By my/our signature(s) below, I/we acknowledge and agree that the Nutritional Therapist is not responsible for any resulting sickness or ailment from any dietary change and/or consuming nutritional supplements. I/we fully understand and accept the risks associated with implementing new dietary changes and consuming nutritional supplements. I/we understand and agree on behalf of myself, my dependents, heirs, administrators, legal representatives, and assigns, to release and hold harmless the Nutritional Therapist, Atma Clinic, LLC and any and all members, employees, agents and representatives thereof, from any and all liability for illness, injuries, or death, and for any losses or damages relating thereto, however occurring, in relation to my use of the services of the Nutritional Therapist. Without limitation, I understand and agree that neither the Nutritional Therapist, Atma Clinic, LLC, nor any members, employees, agents or representatives thereof, is liable for any direct, indirect, consequential, or incidental damage, injury, death, loss, delay, or inconvenience of any kind which may be occasioned by reason of any act or omission, including, without limitation, any willful or negligent act or failure to act, or breach of contract. I/we confirm that I/we have read and fully understand the above disclaimer and waiver of liability are in complete agreement thereto and do freely and without duress sign and consent to all terms contained herein.

CLIENT NAME (PLEASE PRINT) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (HOME) _____ (WORK) _____ (OTHER) _____

SIGNATURE _____ DATE _____

SIGNATURE FOR CLIENT _____

RELATIONSHIP TO CLIENT _____ DATE _____

NUTRITIONAL THERAPY MAY NOT BE COVERED BY INSURANCE AND ALL COSTS ARE THE SOLE RESPONSIBILITY OF THE CLIENT.