INTEGRATIVE MEDICINE CLINIC
1002 Diamond Ridge, Suite 1200 Jefferson City, MO 65109
Phone: 573.632.5585 Fax: 1.844.736.2971 Email: info@imc-jcmo.com

Welcome to the Integrative Medicine Clinic, IMC!

Greetings and welcome to IMC! We are delighted you have chosen IMC to partner with you in reaching your health and wellness goals!

Included in the IMC New Patient Packet are forms that ask for detailed information about your life and your health history. This information allows our integrative and functional medicine specialists to consider all the factors that impact your health and develop your personalized care plan. In order to maximize your time spent at IMC, we request that you complete and return the forms to IMC fourteen days before your new patient appointment. We accept the intake forms via mail, email (info@imc-jcmo.com), fax, or drop off.

First appointment information:

In-person: please arrive 30 minutes before your scheduled appointment

Virtual visit: a member of our staff will contact you 10 minutes before your scheduled appointment and assist you with connecting via telemedicine

Bring or have available the following items:

- ☐ IMC New Patient Packet – complete and return 14 days before appointment
- ☐ List of current medications, vitamins, and supplements
- ☐ Insurance card(s), prescription card, photo ID

We look forward to meeting you,

M. Christopher Link, M.D.

Applying the Principles of
Integrative and Functional Medicine
~Lifestyle + Nutrition~
Optimizing Health Care ONE PATIENT at a Time!

Cancellation/No Show/Reschedule Policy

Thank you for trusting your medical care to Integrative Medicine Clinic (IMC). We respectfully request all patients observe IMC's Appointment Cancellation Policy. Your appointment is important to the IMC team, and this appointment time is reserved especially for you. We understand that sometimes schedule adjustments are necessary. Please remember when you cancel or change your appointment without sufficient notice, someone else will miss the opportunity to have an appointment in that time slot. Please see our policy below:

All appointments MUST be canceled OR rescheduled
no less than 24 hours* before the scheduled appointment.

Effective July 15, 2019, all established patients who no show, cancel, or reschedule their appointment with less than 24 hours* notice will be subject to a $50 cancellation fee.

***NOTE: Monday** appointments must be canceled/rescheduled
by 3p.m. the Friday before the scheduled appointment.

To cancel or reschedule appointments, please call 573-632-5585. If you are not able to get through, please leave a detailed message with your name, date of birth, appointment date, and reason for cancellation/rescheduling.

- Messages left on voicemail over the weekend are **NOT** sufficient notice.
- Three missed, canceled, or rescheduled appointments without sufficient notice within a 12-month period are grounds for dismissal from IMC.
- The cancellation fee is the responsibility of the patient; it is **NOT** covered by insurance.
- **The cancellation fee must be paid before scheduling your next appointment.**

By signing below, you acknowledge that you have received this notice and understand the cancellation policy.

Signature (or Parent/Legal Guardian)	Patient Name	Relationship to Patient
Printed Name	Date	

How would you like to be reminded about your appointment?

Voice Call Yes ☐ No ☐ Number _____

Text Message Yes ☐ No ☐ Number _____

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Today's Date:

PATIENT DEMOGRAPHIC INFORMATION FORM

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Age:
Previous/Maiden Name:	Gender: ☐ Male ☐ Female	
Preferred to be called:	Social Security #:	
Mailing Address:		
If PO Box, Street Address:		
City, State, Zip:		
Email Address:	☐ DO NOT HAVE EMAIL ☐ DO NOT WISH TO SHARE EMAIL ADDRESS	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Partner ☐ Widowed		
Employer:	☐ Unemployed ☐ Retired ☐ Student	

PHONE NUMBERS WHERE WE MAY CONTACT YOU OR LEAVE MESSAGES		
Primary Phone #:	Secondary Phone #:	Work Phone #:

FOR PATIENTS UNDER 18 YEARS OF AGE OR PATIENTS WITH A GUARDIAN/POWER OF ATTORNEY:

RESPONSIBILITY PARTY INFORMATION		
Name:		Date of Birth:
Relationship: ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian ☐ Power of Attorney		Social Security #:
Mailing Address:		
City, State, Zip:		
Employer:		☐ Unemployed ☐ Retired ☐ Student
Primary Phone #:	Secondary Phone #:	Work Phone #:

OTHER PARENT / GUARDIAN INFORMATION		
Name:		Date of Birth:
Relationship: ☐ Father ☐ Mother ☐ Grandparent ☐ Guardian		Social Security #:
Mailing Address:		
City, State, Zip:		
Employer:		☐ Unemployed ☐ Retired ☐ Student
Primary Phone #:	Secondary Phone #:	Work Phone #:

Today's Date:

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Name:	Date of Birth:

ADVANCED DIRECTIVE

Do you have an Advanced Directive? __ Yes __ No

If Yes, is copy of the form on file at a local hospital? ☐ Yes ☐ No

INDIVIDUALS THAT WE ARE AUTHORIZED TO SPEAK TO ABOUT PATIENT'S CARE

In addition to custodial parents/guardians, *Integrative Medicine is authorized to speak to the following individuals:*

Contact #1:	Primary Phone #:
Relationship:	Secondary Phone #:
Contact #2:	Primary Phone #:
Relationship:	Secondary Phone #:
Contact #3:	Primary Phone #:
Relationship:	Secondary Phone #:

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR CHILD PATIENT

In addition to custodial parents/guardians, *the following individuals are authorized to accompany this child to receive medical care:*

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

PHARMACY INFORMATION (LOCAL OR MAIL ORDER)

Primary Pharmacy:	Location:
Alternate Pharmacy:	Location:
Mail Order Pharmacy:	Phone/Fax Number:

PRIMARY CARE PROVIDER

Full Name: _____ City/State: _____

Phone: _____ Fax: _____

Today's Date:

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Name:	Date of Birth:

PATIENT ACKNOWLEDGEMENTS & AUTHORIZATIONS

1. I understand that the Integrative Medicine Clinic (IMC) is a cash only practice with the exception of Traditional Medicare* **(see page 4)** and all payments are due in full at the time of service. Please initial all:
   a. ____ IMC will provide a detailed invoice for each visit.
   b. ____ It is at my discretion to submit the invoice to my insurance company for reimbursement.
   c. ____ IMC is not responsible for how the insurance company processes my claim and IMC is not responsible for the amount of reimbursement determined by my insurance company.
   d. ____ All payments are due in full at the time of service including any outstanding balances with the exception of patients who have traditional Medicare*.
2. I understand that IMC will request to keep my insurance information and prescriptions cards on file. Please initial all:
   a. ____ I verify the insurance information provided is current and correct.
   b. ____ Uses of my insurance information include but are not limited to prior authorizations for testing and medication, referrals to other medical providers, and orders sent to testing facilities.
   c. ____ IMC will not use my insurance information in an attempt to seek reimbursement for services provided with the exception of patients who have traditional Medicare*.
3. I understand that it is my responsibility to notify IMC when changes occur to my personal information including: Please initial all:
   a. ____ Contact information such as mailing address, contact phone number(s), email address
   b. ____ Insurance coverage or prescription drug coverage
   c. ____ Individuals who are authorized to receive information about my medical care
   d. ____ Individuals who are authorized to accompany a minor child and receive information about the minor child
   e. ____ Preferred laboratories, testing facilities, and pharmacies
4. I authorize providers of IMC to examine, administer treatment, and perform procedures as is considered therapeutically or diagnostically necessary. Please initial all:
   a. ____ I understand IMC utilizes an electronic prescribing network for prescription medications involving participating pharmacies and other health care providers in order to reduce medication errors and adverse drug interaction and I consent that IMC may view my medication history.
   b. ____ I authorize representatives of IMC who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me by using any telephone number(s) supplied by me and may leave messages with whomever answers the phone or the associated recorder using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.
5. I understand I can request that a paper copy of the Notice of Privacy Practices be sent to me by mail or that I be provided with an electronic copy through email. I can take a copy of the Notice of Privacy Practices located in the lobby of IMC.
6. I understand certain IMC billing practices. Please initial all:
   a. ____ There is a return check fee of $25 for all return checks.
   b. ____ For all established patients there will be a $50 cancellation/no show fee to be paid before the next appointment. This policy includes all missed appointments or canceled/rescheduled appointments with less than 24-hour notice. Monday appointments must be canceled/rescheduled by 3:00 pm the Friday before the scheduled appointment. (In the event that I am exhibiting symptoms of Covid-19 or if I have had a known or suspected exposure to Covid-19, I understand that I may request to change to a telemedicine appointment.)

Signature of the Adult Patient OR Signature of Responsible Party (for Patients under 18 years of age or with a Guardian/Power of Attorney) **in Agreement to the above Patient Acknowledgements and Authorizations**

X _____ _____

Signature Date

Patient could not sign the acknowledgement because of physical impairment. Patient verbally agreed to the above Patient Acknowledgements and Authorizations.

Staff Signature *Date*

Today's Date:

PATIENT DEMOGRAPHIC INFORMATION FORM

Patient Name:	Date of Birth:

PATIENT ACKNOWLEDGEMENTS & AUTHORIZATIONS

********** Traditional Medicare ONLY **********

Please initial all:

____ I agree to authorize payment from traditional Medicare and supplemental insurance be made to IMC and hereby give my permission to release any information necessary to collect from any third-party payers.

____ IMC will NOT forward claims to secondary insurances if Medicare does not automatically do so.

____ I understand I am responsible to pay all costs not covered by traditional Medicare.

____ I understand that IMC will be considered out-of-network for major insurance companies. IMC does not guarantee how secondary insurances will process or reimburse claims.

X _____ _____

Signature Date

Patient Name: _____ Date of Birth: _____

Primary Care Provider: _____ **Referring Provider:** _____

Current / Recent medical and other health care providers (Please list names; include physical therapy, psychology, etc.):

_____

_____

List Complementary and Alternative therapies or practitioners you have tried (Please list names):

_____

_____

Please describe your goals and expectations regarding your appointment with Integrative Medicine:

_____

_____

Current Medications, Vitamins, and Supplements (please include all prescriptions and over the counter drugs):

☐ **NO CURRENT MEDICATIONS**

Medication Name	Dosage Amount	Take	Frequency	Reason for Medication
EXAMPLE	*15 mg* *2 puffs* *5000 mcg*	*1 tablet* *2 tablets* *1 to 2 tablets*	*Once a Day* *Twice a Day* *As Needed*	*High Blood Pressure* *Diabetes* *High Cholesterol*

Patient's Medical History (please include detail, if applicable):

□ Acid Reflux/Gerd
□ Anemia
□ Anxiety
□ Asthma
□ Asthma (exercise induced)
□ Bleeding Disorders
□ Cancer: _____
□ Cirrhosis
□ Concussion
□ COPD
□ Depression
□ Diabetes
□ Emphysema
□ Erectile Dysfunction
□ Fibromyalgia
□ Gallstones
□ Glaucoma / Cataracts
□ Headaches
□ Heart Attack
□ Heart Disease
□ Heart Murmur
□ Hemorrhoids
□ Hepatitis
□ High Blood Pressure
□ HIV / AIDS
□ Impotence
□ Infertility
□ Migraines
□ Mitral Valve Prolapse
□ Nerve Damage
□ Psoriasis
□ Rheumatic Fever
□ Rosacea
□ Seasonal Allergies
□ Seizures
□ Sleep Disorder
□ Stomach Ulcers
□ Stroke
□ Thyroid Disease
□ Tuberculosis
□ Ulcerative Colitis/Cron's disease
□ Venereal Disease
□ Other: _____

Previous Colonoscopy ☐ **Yes** ☐ **No** Date:_____ Findings:_____
Previous DEXA - Bone Density ☐ **Yes** ☐ **No** Date:_____ Findings:_____
Previous Mammogram ☐ **Yes** ☐ **No** Date:_____ Findings:_____

Immunizations up to date? ☐ **Yes** ☐ **No**
Tetanus within 10 years? ☐ **Yes** ☐ **No**
Pnuemovax? ☐ **Yes** ☐ **No**
Varicella (chickenpox)? ☐ **Yes** ☐ **No**
Hepatitis B series? ☐ **Yes** ☐ **No**
Gardasil (HPV)? ☐ **Yes** ☐ **No**

Patient Name: _____ Date of Birth: _____

Psychiatric History:

Have you ever been treated for emotional problems? ☐ **Yes** ☐ **No**
Have you ever considered or attempted suicide? ☐ **Yes** ☐ **No**

Medication Allergies (List Reactions or write unknown): ☐ **NO KNOWN DRUG ALLERGIES**

Surgical History (Provide year of procedures): ☐ **NO PREVIOUS SURGICAL HISTORY**

Hospitalization(s) (Excluding from surgery, births, or ER visits. Provide date and Reason): ☐ **NO HOSPITALIZATIONS**

Accidents / Trauma (Describe and provide dates of injuries)

Family History (Health Problems or Conditions)**:**

Alive	Deceased	Age of Death		High Blood Pressure	Heart Disease	High Cholesterol	Asthma	Diabetes	Stroke	Breast Cancer	Colon Cancer	Seizures	Lung Cancer	Ovarian Cancer
			Daughter(s)											
			Father											
			Son(s)											
			Mother											
			Paternal Grandfather											
			Paternal Grandmother											
			Maternal Grandfather											
			Maternal Grandmother											
			Paternal Uncle											
			Paternal Aunt											
			Maternal Uncle											
			Maternal Aunt											
			Siblings											
Other Family History:														

# of Siblings _____ Brothers _____ Sisters _____ ☐ Healthy
# of Children _____ Sons _____ Daughters _____ ☐ Healthy

Patient Name: _____ Date of Birth: _____

Social History:

Best way to learn: ☐ **Reading** ☐ **Listening** ☐ **Visual** ☐ **Demonstration** ☐ **No Preference** ☐ **Other:** _____

Barriers to learning: ☐ **Language** ☐ **Culture** ☐ **Hearing** ☐ **Vision** ☐ **Permanent Cognitive Impairment** ☐ **None**

Have you ever smoked or used tobacco? ☐ **No** ☐ **Formerly** ☐ **Currently** Type: _____

How often do you smoke? _____ Amount per day: _____

If former smoker, at what age did you start? _____ Age stopped? _____

Have you used illicit drugs, other than for medical reasons, in the past 12 months? ☐ **Yes** ☐ **No** Type: _____

Are you currently using? ☐ **Yes** ☐ **No** Date of last usage: _____ Age you started using? _____

Did you have a drink containing alcohol in the past year? ☐ **Yes** ☐ **No**

If yes, how often do you have a drink containing alcohol?

☐ **Monthly or Less** ☐ **2 to 4 time a month** ☐ **2 to 3 time a week** ☐ **4 or more time a week**

If yes, how many drinks did you have on a typical day? ☐ **1-2** ☐ **3-4** ☐ **5-6** ☐ **7-9** ☐ **10 or More**

If yes, how often did you have 6 or more drinks on one occasion?

☐ **Less than Monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐ **Partner**

# of adults in the household _____ # of children in the household _____

Occupation: _____ Occupational Exposure? ☐ **Yes** ☐ **No** Exposure type: _____

Special Diet? ☐ **Yes** ☐ **No** If yes, what are your restrictions? _____

Caffeine intake: ☐ **Coffee** ☐ **Soda** ☐ **Tea** ☐ **Energy Drink** ☐ **None** How often? _____

Exercise regularly? ☐ **Yes** ☐ **No** How many times per week? _____ Type: _____

Describe your religion / spirituality: _____

Describe current state of finances: _____

Hobbies / Volunteer Work (current or previous): _____

Sexual History:

(Answers to the following questions help your clinician provide appropriate care for you and help identify your risk for cervical cancer. Leave any questions blank if you are uncomfortable answering them. Please feel free to discuss any concerns with your clinician)

Have you ever had sexual intercourse? ☐ **Yes** ☐ **No**

If yes, the following will apply:

Are you currently sexually active? ☐ **Yes** ☐ **No**

Have your sexual partners been: ☐ **Men** ☐ **Women** ☐ **Both**

What was your age at first intercourse? _____

Total number of lifetime partners: _____ Number of partners in the last 12 months: _____

Have you had intercourse without contraception since your last menstrual period? ☐ **Yes** ☐ **No**

Have you had intercourse without a condom since your last STD testing? ☐ **Yes** ☐ **No**

Does your partner have any symptoms of infection? ☐ **Yes** ☐ **No**

Have you experienced any unwanted sexual encounters? ☐ **Yes** ☐ **No**

GYN History:

First day of last menstrual period: _____

Age at first menstrual period: _____ # of days between periods: _____ Length of periods: _____

Age at menopause: _____

Method of birth control: ☐ **Condoms** ☐ **Oral Contraceptive** ☐ **IUD** ☐ **Shot** ☐ **None** ☐ **Other:** _____

Date of last PAP: _____ Results: ☐ **Normal** ☐ **Abnormal**

History of abnormal PAP? ☐ **Yes** ☐ **No** Treatment: _____

Do you do self-breast exams? ☐ **Yes** ☐ **No** Have you ever found a lump? ☐ **Yes** ☐ **No**

Patient Name: _____ Date of Birth: _____

OB History:

Total # of pregnancies: _____ Total # of full-term deliveries: _____ Total # of pre-term deliveries: _____
Total # of miscarriage(s): _____ Total # of abortion(s): _____ Total # of ectopic pregnancies: _____
Total # of multiple birth(s): ____

Please circle any of the below items that have affected you in the past 6 months.

General: Binge eating/ drinking Craving certain foods Excessive weight Compulsive eating Water retention Currently underweight Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness Frequent illness Other: _____	**Head/Eyes/Ears/Nose/Throat:** Headaches Faintness Dizziness Insomnia Swollen/discolored tongue, gums, lips Canker sores Itchy ears Earaches, ear infections Drainage from ears Ringing in ears Hearing loss Watery or itchy eyes Swollen, reddened, or sticky eyelids Bags or dark circles under eyes Blurred or tunnel vision Stuffy nose Sinus problems Hay fever Sneezing attacks Excessive mucous formation Chronic cough Gagging/ frequent need to clear throat Sore throat Hoarseness/ loss of voice Other: _____	**Gastrointestinal:** Nausea Vomiting Diarrhea Constipation Bloating Belching Passing gas Heartburn Intestinal/ stomach pains Other: _____	**Musculoskeletal:** Pain or aches in joints Arthritis Stiffness or limited movement Pains or aches in muscle Feeling of weakness or tiredness Other: _____	**Neurological:** Poor memory Confusion/ poor comprehension Poor concentration Poor physical coordination Difficulty in making decisions Stuttering/ stammering Slurred speech Learning difficulty Other: _____
Respiratory: Chest congestion Asthma Bronchitis Shortness of breath Difficulty breathing Other: _____		**Cardiovascular:** Irregular heart rate Skipped heartbeat Fast/pounding heart rate Chest pain Other: _____	**Skin:** Acne/pimples Hives/rashes Hair loss Dry skin/ scalp Flushing/ hot flashes Excessive sweating Other: _____	**Genitourinary:** Urinary Frequency Urinary Urgency Genital itch or discharge Other: _____

If you are experiencing pain now or having on-going pain, please fill out the following section.

Location: _____
Quality: _____
Radiation: _____
What makes it better? _____
What makes it worse? _____
How long have you had it? _____

Circle on the line for your current pain level:

No Pain **Excruciating Pain**

0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities and sleep:

_____

_____

_____

How would you describe your health (circle one): **Poor** **Average** **Good**

List the things that cause you the most stress in your life now (e.g. relationships, family, health, money, job, etc.) and number them in order of significance

_____

_____

_____

Patient Name: _____ Date of Birth: _____

How would you rate your stress level in the past month? Circle the appropriate spot on the line below:

No Stress **Extremely Stressed**

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month? Circle the appropriate spot on the line below:

Unhappy **Happy**

0 1 2 3 4 5 6 7 8 9 10

What do you do for relaxation/coping?

_____

_____

When do you have the highest energy level (circle one)? **Morning** **Afternoons** **Evenings**

When do you have the lowest energy level (circle one)? **Morning** **Afternoons** **Evenings**

Please describe how fatigue or low energy affects your daily activities:

_____

_____

Please describe your mood:

_____

_____

Describe your sleep (in general):

_____

_____

Please describe how sleep deprivation affects your daily activities:

_____

_____

Diet and Nutrition History:

Do you drink coffee/tea? ☐ **Yes** ☐ **No** If yes, how much per day? _____

Do you drink soda? ☐ **Yes** ☐ **No** If yes, how much per day? _____

Are there any types or groups of foods you crave or eat a lot? _____

Are there any types or groups of foods you dislike or rarely eat? _____

What do you drink on a typical day? _____

Recall of dietary intake: Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.

Breakfast:

_____

_____

Patient Name: _____ Date of Birth: _____

Recall of dietary intake continued:

Lunch:

Dinner:

Snacks:

Is this a typical day? If not, please describe:

What type of oil do you cook with? _____

What type of spreads do you add to your foods? _____

How many cups (8 oz.) of water do you drink on a typical day? _____

How many servings of fruit do you eat on a typical day? _____
(1 serving = 1 small piece, or ½ cup juice, or ½ cup canned or chopped, or ¼ cup dried)

How many servings of vegetables do you eat on a typical day? _____
(1 serving = 1 small piece, or 1 cup fresh leafy greens, or ½ cup raw or cooked, or ¼ cup dried)

Please describe your relationship to food:

Highest weight ever: _____ Desired weight: _____

Please describe your childhood:

How would you rate your health as a child (circle one)? **Good** **Fair** **Poor**

Please list any major traumas (emotional, verbal, physical, and sexual) you have experienced:

Is there any other information that you would like to share with us?

Patient Name: _____ Date of Birth: _____

Preventative Testing/Treatment Questionnaire

Flu Vaccination (ALL AGES):

When was your last flu shot? _____

Where did you get your flu shot? _____

If you have not received one this season, would you like one today? ☐ **YES** ☐ **NO**

Colonoscopy (IF YOU ARE BETWEEN THE AGES 50 - 75 YEARS OLD)

Have you ever had a colonoscopy? ☐ **YES** ☐ **NO**

If yes, when did you have it and where? _____

If no, would you be interested in having one? ☐ **YES** ☐ **NO**

Mammogram (IF YOU ARE A WOMAN BETWEEN 50 – 75 YEARS OLD)

When was your last mammogram? _____

Where was your last mammogram? _____

If you haven't had one in the last 2 years, can we schedule one for you? ☐ **YES** ☐ **NO**

DEXA – Bone Density (IF YOU HAVE HAD ONE IN THE LAST 2 YEARS)

Have you ever had a DEXA? ☐ **YES** ☐ **NO**

If yes, When/Where was your last DEXA? _____

Pneumonia Vaccine (65 YEARS AND OLDER)

Have you had a pneumonia vaccine? ☐ **YES** ☐ **NO**

If yes, where/when was your last Pneumonia vaccination? _____

If no, are you interested in receiving one? ☐ **YES** ☐ **NO**

Patient Name: _____ Date of Birth: _____

Thank you for taking the time to complete this extensive form. This information will help you and your provider to design the best treatment plan for you.

We look forward to working with you to meet your health and wellness goals.

If you are not able to keep your appointment, please call 72 hours* in advance to reschedule.

***NOTE:**

- **Monday** appointments must be rescheduled by the Thursday before your scheduled appointment.
- **Tuesday** appointments must be rescheduled by the Friday before your scheduled appointment.

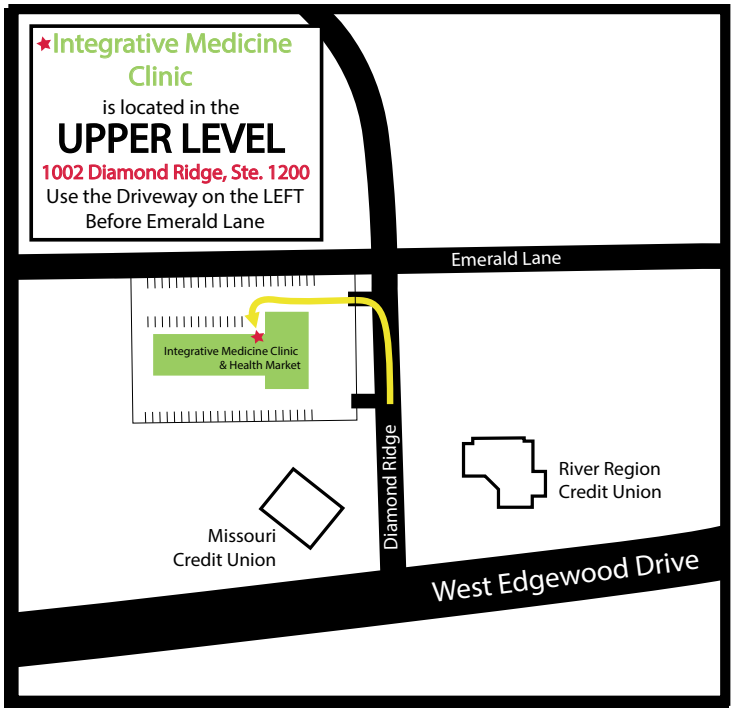
Please be aware that it may be several weeks/months before there is an opening to reschedule the appointment.

□ Check this box if you would like for your name to be placed on a cancelation list; please complete and return this form within 2 weeks receipt.

INTEGRATIVE MEDICINE CLINIC

1002 Diamond Ridge, Suite 1200 Jefferson City, MO 65109 – 573.632.5585

DIRECTIONS:



From St. Louis:

- 1-70 West to US-54 West
- Take US-54 W Exit (Kingdom City) — turn left onto US-54 W
- Just after MO River Bridge take US-50 exit – 3rd exit to the right (after Main and McCarty Street Exits)
- Take Exit for HWY 179 — turn left onto 179
- Turn right onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- Take the 4th possible left turn, 1002 Diamond Ridge Center (Look for the INTEGRATIVE MEDICINE CLINIC sign at the second entrance). Our clinic is located in the 1st building accessed through the breezeway (North side of the building).

From Columbia:

- US 63 South towards Jefferson City
- Just after MO River Bridge take US-50 exit – 3rd exit to the right (after Main and McCarty Street Exits)
- Take the Exit for HWY 179 — turn left onto 179
- Turn right onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- Take the 4th possible left turn, 1002 Diamond Ridge Center (Look for the INTEGRATIVE MEDICINE CLINIC sign at the second entrance). Our clinic is located in the 1st building accessed through the breezeway (North side of the building).

From Kansas City:

- 1-70 East and then from Columbia, follow the above directions.
  OR
- Take US-50 East toward Jefferson City
- Take the Exit for HWY 179 — turn right onto 179
- Turn right onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- Take the 4th possible left turn, 1002 Diamond Ridge Center (Look for the INTEGRATIVE MEDICINE CLINIC sign at the second entrance). Our clinic is located in the 1st building accessed through the breezeway (North side of the building).

From Lake of the Ozarks:

- Take US-50 East toward Jefferson City
- Turn left onto US-54 E
- Continue straight to stay on US-54 E
- Use the right lane to take the MO-179/Missouri B ramp to Wardsville
- Turn left onto MO-179 N/Rte. B St Hwy B
- Use the left 2 lanes to turn left onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- Take the 4th possible left turn, 1002 Diamond Ridge Center (Look for the INTEGRATIVE MEDICINE CLINIC sign at the second entrance). Our clinic is located in the 1st building accessed through the breezeway (North side of the building).

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Lifestyle + Nutrition