





**INTEGRATIVE MEDICINE CLINIC**  
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## **First Appointment Cancellation Policy**

We respectfully request all patients observe IMC's First Appointment Cancellation Policy. Your first 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.

**The Initial Intake and Assessment Fee is partially refundable** for appointments canceled at least 3 business days (72 hours\*) before your scheduled appointment. You will be refunded your initial payment less a \$50 processing fee.

**Appointments canceled less than 3 business days (72 hours) before your scheduled appointment will NOT be refunded.**

**\*NOTE:**

- **Monday** appointments must be canceled by the Thursday before your scheduled appointment to receive a partial refund.
- **Tuesday** appointments must be canceled by the Friday before your scheduled appointment to receive a partial refund.

Thank you for your understanding.

We look forward to meeting you,

M. Christopher Link, M.D.  
Jalyn North, MSN-FNP  
Rachel Lenon, FNP-BC

## Directions to INTEGRATIVE MEDICINE CLINIC

### ***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
- We are at the top of the hill on the right in the Fisher Building. Look for the INTEGRATIVE MEDICINE CLINIC sign then take the second entrance. **Our clinic is accessed from the upper parking lot (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 Exit for HWY 179 — turn left onto 179
- Turn right onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- We are at the top of the hill on the right in the Fisher Building. Look for the INTEGRATIVE MEDICINE CLINIC sign then take the second entrance. **Our clinic is accessed from the upper parking lot (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 Exit for HWY 179 — turn right onto 179
- Turn right onto West Edgewood (stoplight)
- Turn right onto Diamond Ridge
- We are at the top of the hill on the right in the Fisher Building. Look for the INTEGRATIVE MEDICINE CLINIC sign then take the second entrance. **Our clinic is accessed from the upper parking lot (North side of the building).**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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 (please include all prescriptions and over the counter drugs):  NO CURRENT MEDICATIONS

Medication Name	Dosage Amount (Ex. 15 mg, 2 puffs, 5 meq)	Take (Ex. 1 tablet, 2 tablets 1 to 2 tablets)	Frequency (Ex. Once a day, Twice a day, as needed)	Reason for Medication (Ex. High blood pressure, diabetes, high cholesterol)

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

- Anxiety
- Asthma
- Asthma, exercise induced
- Bleeding Disorders
- Cancer \_\_\_\_\_
- Cirrhosis
- Concussion
- COPD
- Other: \_\_\_\_\_
- Depression
- Diabetes
- Eczema
- 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
- Venereal Disease

Previous Colonoscopy: Yes or No Date: \_\_\_\_\_ Findings: \_\_\_\_\_

Previous Bone Density: Yes or No Date: \_\_\_\_\_ Findings: \_\_\_\_\_

Previous Mammogram: Yes or No Date: \_\_\_\_\_ Findings: \_\_\_\_\_

Immunizations up to date? Yes or No

Tetanus within 10 years? Yes or No

Pneumovax? Yes or No

Varicella (chickenpox)? Yes or No

Hepatitis B series? Yes or No

Gardasil (HPV)? Yes or No

Psychiatric History:

Have you ever been treated for emotional problems? Yes or No

Have you ever considered attempted suicide? Yes or No

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**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	Colon Cancer	Breast Cancer	Lung Cancer	Ovarian Cancer	Seizures
			Mother											
			Father											
			Sibling(s)											
			Maternal Grandmother											
			Maternal Grandfather											
			Paternal Grandmother											
			Paternal Grandfather											
			Maternal Aunt											
			Maternal Uncle											
			Paternal Aunt											
			Paternal Uncle											
<b>Other Family History:</b>														

# of Siblings – Brothers \_\_\_\_\_ Sisters \_\_\_\_\_  Healthy

# of Children – Sons \_\_\_\_\_ Daughters \_\_\_\_\_  Healthy

**Social History:**

Have you ever smoked or used tobacco? **No** or **Formerly** or **Currently** Type: \_\_\_\_\_

How often do you smoke? \_\_\_\_\_ Amount per day: \_\_\_\_\_

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

Best way to learn:  Reading  Listening  Visual  Demonstration  No Preference  Other: \_\_\_\_\_

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

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Social History Continued:**

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

Are you currently using? **Yes** or **No** Date of last usage: \_\_\_\_\_ Age you started using? \_\_\_\_\_

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

If yes, how often did you have 6 or more drinks on one occasion?  2-3 times/week  4 or more times/week  Monthly or Less

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

If yes, how often do you have a drink containing alcohol?  Daily  Weekly  Monthly  Less than monthly

Marital Status:  Single  Married  Separated  Divorced  Widowed  Partner

# of adults in the household \_\_\_\_\_ # of children in the household \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupational Exposure? **Yes** or **No** Exposure type: \_\_\_\_\_

Special Diet? **Yes** or **No** If yes, what are your restrictions? \_\_\_\_\_

Caffeine intake:  Coffee  Soda  Tea  Energy Drink  None How often? \_\_\_\_\_

Exercise regularly? **Yes** or **No** How many times per week? \_\_\_\_\_ Type: \_\_\_\_\_

Describe your religion / spirituality: \_\_\_\_\_

Describe current state of finances: \_\_\_\_\_

Hobbies / Volunteer Work (current or previous): \_\_\_\_\_

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**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** or **No**

**If yes, the following will apply:**

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

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

What was your age at first intercourse? \_\_\_\_\_

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

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

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

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

Have you experienced any unwanted sexual encounters? **Yes** or **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** or **Abnormal**

History of abnormal PAP? **Yes** or **No** Treatment: \_\_\_\_\_

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

**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): \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

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

<b>General:</b> Binge eating/ drinking Craving certain foods Excessive weight Compulsive eating Water retention Currently underweight Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness Frequent illness Other: _____	<b>Head/Eyes/Ears/Nose/Throat:</b> 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	<b>Gastrointestinal:</b> Nausea Vomiting Diarrhea Constipation Bloating Belching Passing gas Heartburn Intestinal/ stomach pains Other: _____	<b>Musculoskeletal:</b> Pain or aches in joints Arthritis Stiffness or limited movement Pains or aches in muscle Feeling of weakness or tiredness Other: _____	<b>Neurological:</b> Poor memory Confusion/ poor comprehension Poor concentration Poor physical coordination Difficulty in making decisions Stuttering/ stammering Slurred speech Learning difficulty Other: _____
<b>Respiratory:</b> Chest congestion Asthma Bronchitis Shortness of breath Difficulty breathing Other: _____	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: _____	<b>Cardiovascular:</b> Irregular heart rate Skipped heartbeat Fast/pounding heart rate Chest pain Other: _____	<b>Skin:</b> Acne/pimples Hives/rashes Hair loss Dry skin/ scalp Flushing/ hot flashes Excessive sweating Other: _____	<b>Genitourinary:</b> 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? \_\_\_\_\_

Mark an X on the line where your pain is currently:

*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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How would you rate your stress level in the past month? Place an X or 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? Place an X or circle the appropriate spot on the line below:

*Unhappy* \_\_\_\_\_ *Happy*

0 1 2 3 4 5 6 7 8 9 10

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

What do you do for relaxation/coping?

\_\_\_\_\_  
\_\_\_\_\_

When do you have the highest energy level?

\_\_\_\_\_ Morning \_\_\_\_\_ Afternoons \_\_\_\_\_ Evenings

When do you have the lowest energy level?

\_\_\_\_\_ 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** or **No** If yes, how much per day? \_\_\_\_\_

Do you drink soda? **Yes** or **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:* \_\_\_\_\_

*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 own health as a child? **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: \_\_\_\_\_

DOB: \_\_\_\_\_

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** (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: \_\_\_\_\_

DOB: \_\_\_\_\_

**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 48 hours in advance to reschedule. 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.*