LivingWell
INTEGRATIVE HEALTHCARE
www.LivingWellHealthcare.com

~Also Find us on Facebook~

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Welcome to LivingWell Integrative Healthcare. We congratulate you on beginning your journey to better health. We are honored to partner with you in achieving your wellness potential.

Patient Name:_____ Date:

This is to confirm my appointment on _____at

with _____.

Please find your New Patient Information Packet attached. **Please read, complete, and sign all forms prior to your appointment. If you are not filling them in online, please bring them with you to your appointment.**

Please arrive **15 minutes prior** to your scheduled appointment, and bring all recent lab results and any medications or supplements that you are taking.

Cancellation Policy:
If you wish to cancel or reschedule your appointment, please notify our office at least **48 hours prior**, and we will assist you with this. Patients failing to show for an appointment or canceling less than 48 hours prior **will be charged the total cost of the missed appointment.** It is our office policy to confirm appointments by phone two days prior to appointments. Please provide us with your preferred contact information for appointment reminders.

We require a credit card to confirm your appointment at the time of scheduling and this first visit will be charged at that time. The credit card information will be kept confidentially in your chart.

Thank you for choosing LivingWell Integrative Healthcare!
Cheryl Middleton, PA-C
Andrea N. Wininger, MD, FACOG
James Clif Caldwell, MD

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Demographic Information *Today's Date:*_____

Name: _____ *Date of Birth:* _____
LAST *FIRST* *MIDDLE*

Address: _____
STREET CITY STATE/PROV. ZIP CODE

*Telephone: Home: (___)*_____ *Cell: (___)*_____ *Work: (___)*
WITH AREA CODE

Email:

Employer: _____*Occupation:*

Driver's License No. _____*Social Security No.*

Referred By:

Spouse's Name:

Marital History: Years married _____ *# Children:* _____ *Ages:*

EMERGENCY CONTACT: (Provide name & phone number)
*Name:*_____ *Relationship to patient:*

*Phone: (___)*_____

Primary Care Provider:

*Current Ob/Gyn Physician:*_____

*Other Physicians:*_____

Patient Name:

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Medical and Family History (check all that apply)

	Self	***First Degree Relative(who)***
Thyroid	____	_____
Breast Cancer	____	_____
High Blood Pressure	____	_____
Heart Disease	____	_____
Diabetes	____	_____
Autoimmune Disease	____	_____
Kidney Disease	____	_____
Liver Disease	____	_____
Sleep Apnea	____	_____
Other	____	_____

List all surgeries you have had with dates:

_____

Obstetric History:

#of Pregnancies: ____ #of Deliveries____ Method of Delivery: _____

Complications during pregnancies or deliveries: _____

_____

Patient Name:_____

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Gynecology History:

First day of Last Menstrual Period: (If menopausal, indicate when menses stopped)

Menstrual Complaints:

History of Abnormal Pap Smears? (If Treatment required for abnormal pap, please detail)

Last Pap Smear (date, results)
Last Mammogram (date, results)
Bone Density Exam (date, results)

Current Birth Control Method? _____

*Age at onset of periods*_____
Any hormonal medications used currently or in the past (birth control pills, hormone replacement therapies):

What/whom in your life gives you the most support and comfort?

_____

_____

Vaccination History: Are your vaccinations up to date? Yes__ No__
Tetanus: Yes__ No__ Hepatitis B:Yes__ No__
Other vaccinations: _____

Allergies and Sensitivities: *(Medications, Foods, Environmental)*_____

_____

Patient Name:_____

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MEDICATIONS/SUPPLEMENTS: Please complete this medication form with any prescription or non-prescription medications, vitamins or other supplements.

Medication/ Supplement	***Form (pill, cream, etc)***	***Dosage***	***Times Per Day***

Allergies to Medications:

Name of Medication	Symptom it Caused

*Patient Name:*_____

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Social History/Lifestyle factors:
Diet:

Indicate how often:	*Never*	*Occasionally*	*Weekly*	*Daily*
Coffee/Tea				
Tobacco				
Alcohol (type)				
Artificial Sweetener				

Describe typical meal choices and approximate time each day:

Breakfast:

Mid-morning snack:

Lunch:

Afternoon snack:

Supper:

Evening snack:

Stress Level: *High*_____ *Moderate* _____ *Low/None*

Average hours of sleep per night: _____ *Sleep Quality:*

Average amount of water (glasses or ounces) consumed per day:

Exercise activities: (Indicate type of activity, duration, and times per week)

Patient Name:

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Symptom	Current	Past
Fatigue		
Hot flashes/night sweats		
Vaginal dryness		
Brain fog		
Sleep problems		
Mood swings		
Puffy hands/rings don't fit		
Weight gain		
Anxiety/irritable		
Low sex drive		
Hair loss		
Headaches		
Loss of sense of well-being		
PMS		
Unwanted hair		
Acne		
Lack of Motivation		
Sugar/salt cravings		
Cold hands/feet		
Dry hair/skin		

What top 3 symptomatic improvements would increase your quality of life?

*1.*_____

*2.*_____

*3.*_____

Patient Name:

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Please Read the Following LivingWell Policies Carefully.

We are honored to partner with you in achieving your wellness goals. We recognize and value the trust that you have bestowed upon us. In order to preserve a great relationship with our patients, we're providing the following information concerning how we do business and how we can best provide healthcare services.

Payment Requirements: *Payment is expected for all services at the time of service. Your initial appointment will be charged to your credit card the day it is made. We gladly accept all major credit/debit cards.*

Insurance information:
LivingWell Integrative Healthcare does not bill ANY insurance companies. None of our providers are "preferred providers" for any insurance company.
We work for you instead of an insurance company. Our goals are to provide services based on your individual healthcare needs, without a third party intruding on your healthcare choices. We will provide initial assistance in filling out your insurance reimbursement forms (unless you have Medicare or Medicaid, see below). Please be aware that some insurance companies will not reimburse for our fees. If assistance with additional forms is required, there will be a fee for this service.

Medicare/Medicaid please read the following information carefully:
All of our providers have "Opted Out" of Medicare. We are NOT Medicare providers and our services are NOT BILLABLE OR REIMBURSABLE TO MEDICARE. Therefore you CANNOT file for reimbursement of any kind.

I have read, understand and agree with the above statements.

Please Print Name *Signature* *Date*