LivingWell
INTEGRATIVE HEALTHCARE

838 Powdersville Rd | Suite G | Easley, SC 29642
P: 864-850-9988 | F: 864-850-9989

New Male Patient Form

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: ______________ ______________ ______________
First Middle Last

Today's Date: ______________

This is to confirm my appointment on ______________ **at** ______________ **with**
Date Time

____
Provider Name

Your New Patient Information Form is below. **Please read, complete and sign all forms prior to your appointment. If you are not filling them out 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 medication 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 who cancel less than 48 hours in advance **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!

James 'Clif' Caldwell, MD

Cheryl Middleton, PA-C

Travey Schofield, NP-C

Patient Information

Date of Birth: ______________________
MM/DD/YYYY

Address: ______________________
Street Line 1

____
Street Line 2

____
City, Street, Zipcode

Phone: ______________ ______________ ______________
Cell Work Home

Email: ______________________ Employer: ______________________

Occupation: ______________________ Driver's License No. ______________________

Last 4 Digits of SSN: ______________________

How were you referred to our office? ______________________

Marital Information

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Spouse's Name: ______________________ Years Married: ______________________

Number of children and their ages: ______________________

____

____

Emergency Contact

Emergency Contact: ______________________ ______________________

Name | Phone

____

Relationship to Patient

Providers & Physicians

Primary Care Provider: ______________________

Other Physicians: ______________________

____

Medical & Family History

Please check all that apply:

Condition	Self	First Degree Relative (who)
Thyroid	☐	☐
Prostate Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Autoimmune Disease	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Sleep Apnea	☐	☐

Other medical and family history: ______________________

____

____

List all surgeries you have had with dates: ______________________

____

____

Exams:

	Date and Location	Results
Last Rectal Exam/Prostate Exam		
Last Colonoscopy		
Last PSA Blood Test		

Vaccination History

Are your vaccinations up to date? ☐ Yes ☐ No

Hep B ☐ Yes ☐ No **Tetanus** ☐ Yes ☐ No **COVID-19** ☐ Yes ☐ No

Flu ☐ Yes ☐ No **Pneumonia** ☐ Yes ☐ No

Other Vaccinations: ______________________________

Medications/Supplements

List all prescription or non-prescription medications, vitamins or other supplements

Medication/Supplement	Form (pill, cream, etc.)	Dosage	Times/day

Allergies to Medications:

Name of Medication	Symptom/Reaction it Caused

Diet

Please indicate how often you consume the following:

	Never	Occasionally	Weekly	Daily
Coffee/Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Artificial Sweetener	☐	☐	☐	☐
Alcohol (type: _______________)	☐	☐	☐	☐

Daily Water Consumption (in glasses or oz): ____________________

Describe typical meal choices and approximate time each day:

	Typical Choice	Time of Day
Breakfast		
Mid-Morning Snack		
Lunch		
Afternoon Snack		
Supper		
Evening Snack		

Stress Level ☐ High ☐ Moderate ☐ Low ☐ None

Avg Hours of Sleep per Night: ____________ Sleep Quality: ____________________

Exercise Activities

Activity	Duration	Times/week

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

____

Symptoms

Please check all that apply:

	Current	Past
Fatigue	☐	☐
Burned Out Feeling	☐	☐
Lack of Motivation	☐	☐
Decreased Strength	☐	☐
Poor Recovery from Injury	☐	☐
Joint Pains	☐	☐
Low Sex Drive	☐	☐
Impotence	☐	☐
Sleep Problems	☐	☐
Brain Fog	☐	☐
Irritability/Anxiety	☐	☐
Weight Gain	☐	☐
Loss of Muscle Mass	☐	☐
Headaches	☐	☐
Sugar/Salt Cravings	☐	☐
Cold Hands/Feet	☐	☐
Dry Skin/Hair	☐	☐
Acne/Oily Skil	☐	☐
Emotional Instability	☐	☐
Heart Palpitations	☐	☐

Other symptoms: ______________________________

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

1. ______________________________
2. ______________________________
3. ______________________________

Office Policy Information

Please read the following LivingWell policies carefully

Thank you for choosing us for your healthcare needs. We are here to help you with your health. The following is to assist you in understanding the LivingWell Integrative Healthcare policies. Please read them carefully, initial each section and sign after reading.

Payment Requirements: Appointments must be paid for at the time of service. We do not file insurance for our services. We accept Visa, MasterCard, America Express, Discover, check and cash. There is a $35.00 charge for return checks. As a courtesy, we submit your insurance to the laboratories for them to file insurance. Any discrepancies with your lab bill would need to be directed to the lab company.

Insurance and Medicare/Medicaid: LivingWell Integrative Healthcare **DOES NOT** file insurance claims or participate in insurance. None of our providers are "preferred providers" for any insurance program. We are **NOT** Medicare/Medicaid providers, and our services are **NOT BILLABLE TO MEDICARE/MEDICAID AND MOST SUPPLEMENT INSURANCES**. We can provide a receipt for a patient with commercial insurance to assist with reimbursement.

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

______________________________	______________________________
Signature	Date

____

Printed Name