

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: _____

Current OB/GYN: _____

Other Physicians: _____

Medical & Family History

Please check all that apply:

Condition	Self	First Degree Relative (who)
Thyroid Issues	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Other medical and family history: _____

List all surgeries you have had with dates: _____

Exams:

	Date and Location	Results
Last Pap Smear		
Last Mammogram		
Bone Density Exam		

Obstretic History

of Pregnancies: _____ # of Deliveries: _____

Method of Deliveries: _____

Complications during pregnancies or deliveries: _____

Gynecological History

Age at onset of period: _____

First day of last menstrual period (If menopausal, indicate when menses stopped): _____

Menstrual compaints: _____

History of abnormal pap smears? Yes No

Describe treatment required for abnomal pap smear, if applicable: _____

Any hormonal medication used currently or in the past (birth control pills, hormone replacement therapy, etc.)?

Yes No

If yes, please specify: _____

Current birth control method: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweetener	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes/Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>
Puffy Hands/Rings don't fit	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sense of Well-Being	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>
Unwanted Hair	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Motivation	<input type="checkbox"/>	<input type="checkbox"/>
Sugar/Salt Cravings	<input type="checkbox"/>	<input type="checkbox"/>
Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin/Hair	<input type="checkbox"/>	<input type="checkbox"/>

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