

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate 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 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 | <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"/> |
| Burned Out Feeling | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of Motivation | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased Strength | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor Recovery from Injury | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Pains | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Sex Drive | <input type="checkbox"/> | <input type="checkbox"/> |
| Impotence | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain Fog | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability/Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Muscle Mass | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <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"/> |
| Acne/Oily Skil | <input type="checkbox"/> | <input type="checkbox"/> |
| Emotional Instability | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Palpitations | <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