

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	Middl	۵	La	ict
Today's Date:			C		
This is to confirm m	y appointment on	Date	at	Time	with
Provider	Name				
your appointment. appointment.	formation Form is below If you are not filling the	m out online, pl	ease bring	them with you	to your
	utes prior to your sched upplements that you are		ent, and brir	ng all recent lab	results and
and we will assist yo 48 hours in advance to confirm appointm	or reschedule your appou u with this. Patients failin will be charged the tota nents by phone two days formation for appointme	ng to show for an al cost of the mi prior to appoint	n appointm ssed appoi	ent or who cand ntment . It is oui	el less than office policy
	card to confirm your app me. The credit card infor				
Thank you for choos	ing LivingWell Integrative	e Healthcare!			
James 'Clif' Caldwell,	MD				
Cheryl Middleton, PA	4- <i>C</i>				

Lindsey Wasson, NP-C

Patient Information

Date of Birth:			
Date of Birth:	_		
Address:	Characteristics of		
	Street Line 1		
	Street Line 2		
	Street Line 2		
	City, Street, Zipcode		
Phone:			
Cell	Work		Home
Email:	Employer:		
Occupation:	Driver's License	e No	
Last 4 Digits of SSN:			
	_		
How were you referred to our office?			
Marital Information			
Walital IIIIOI IIIatioii			
Marital Status: Single Married	Separated	Divorced	Widow(er)
Spouse's Name:	Years Ma	rried:	
Number of children and their ages:			

Emergency Contact

Emergency Contact:		
	Name	Phone
		Relationship to Patient
Providers & Physiciar	ıs	
Primary Care Provider:		
Other Physicians:		
Medical & Family His	tory	
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 his	tory:	
List all surgeries you have ha	d with dates:	
List all saigeries you have ha	a 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	9 Yes	No		
Flu Yes No Pneumonia	Yes No				
Other Vaccinations:					
Medications/Supplements List all prescription or non-prescripti	on medications, vitamins o	r other suppler	nents		
Medication/Supplement	Form (pill, cream, etc.)	Dosage	Times/day		
Allergies to Medications:					
Name of Medication	Symptom	Symptom/Reaction it Caused			

Diet

Please indicate	e how ofter	n you consume	the following:

	Nev	er C	Occasionally	Wee	kly	Daily
Coffee/Tea						
Tobacco						
Artificial Sweetener						
Alcohol (type:	_)					
Daily Water Consumption (i	n glasses or o	z):				
Describe typical meal choic	es and approx	imate time	e each day:			
		Typical	Choice		Т	ime of Day
Breakfast						
Mid-Morning Snack						
Lunch						
Afternoon Snack						
Supper						
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh	Moderate [None eep Quality:			
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh Exercise Activities	_	Sle	eep Quality:			
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh	_	Sle			Tim	ies/week
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh Exercise Activities	_	Sle	eep Quality:		Tim	ies/week
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh Exercise Activities	_	Sle	eep Quality:		Tim	ies/week
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh Exercise Activities	_	Sle	eep Quality:		Tim	ies/week
Supper Evening Snack Stress Level High Avg Hours of Sleep per Nigh Exercise Activities	_	Sle	eep Quality:		Tim	ies/week

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 improv	ements would	l increase youi			
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 state	ements.
Signature	Date
Printed Name	_