LIVING WELL
WELLNESS

PATIENT REGISTRATION FORM

Patient Name: _____ Birthdate: _____

Address: _____Apartment: _____

City, State Zip Code _____ SSN _____ - _____- _____

Best Contact Number _____Alternate Number _____

Email Address _____

Alternate Names used for PDMP _____

Emergency Contact _____Phone Number _____

Please list any doctors who have prescribed controlled substances for you. Failure to disclose this information may lead to your dismissal as a patient of LWW.

Doctor	Phone Number	Date Last Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With my signature, I affirm that all of the information provided is true and I have omitted nothing. I waive any applicable privilege and give permission to Living Well Wellness to obtain my medical records and discuss my medical history with any physicians, hospitals, clinics, diagnostic centers, pharmacies, insurance companies, family and law enforcement without violating HIPPA. I hold Living Well Wellness, its officers, directors, employees and contractors harmless for any information that may be discussed with any physician, hospital, clinic, diagnostic center, pharmacy, insurance company, family and law enforcement.

_____ _____

Patient Signature Date

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HIPPA Privacy Agreement

Due to Federal HIPPA patient privacy regulations I agree to not discuss my treatment with other patients at anytime while I am a patient of Living Well Wellness.

Patient:_____ Date:_____

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MEDICAL LIABILITY RELEASE FORM

Living Well Wellness's Policy for Malpractice. As per Florida Law we post on the wall that the doctor does not cary malpractice insurance. The patient agrees not to hold Living Well Wellness and Its Physicians and Staff responsible for any medical liability. The New Patient must complete this form to be eligible for Addiction Therapy care at Living Well Wellness.

PLEASE TYPE OR PRINT ALL INFORMATION
Patients Name:
Home Address:
Date Of Birth:
Telephone:
Patients Primary Care Physician:

LIABILITY RELEASE: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her emergency care. I hereby release the Living Well Wellness and its Physicians and Staff any legal or financial responsibility.

PATIENT /PARENT/GUARDIAN: Please check one of the following and sign your name.
_____ I give my permission for immediate medical treatment as required in the judgment of the attending physician. Notify me and/or any persons listed above as soon as possible.
_____ I do not give permission for medical treatment until I have been contacted.

Parent/Guardian's Signature _____

Date _____
(the above line is applicable for delegates under the age of 18 and must be signed by the parent or legal guardian.)

Patients Signature _____

Date _____

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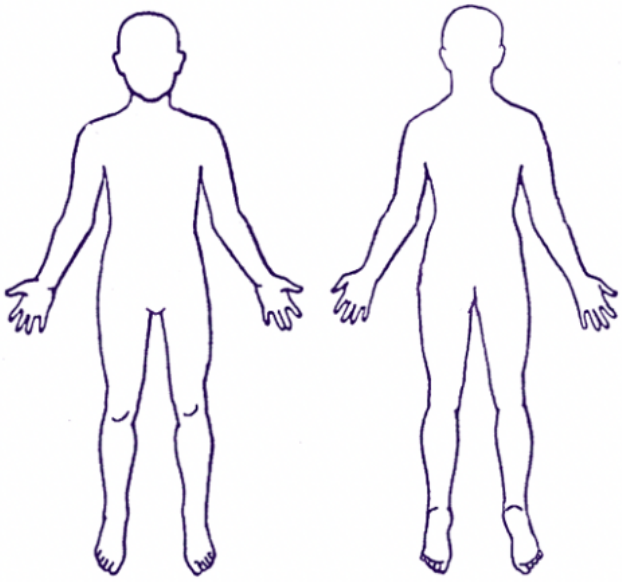
Health History

_____
Patient Name

1. Please mark anywhere you may have pain and if it travels or radiates:



XXXXX-Pain
OOOOO-Numbness
////////-Aching
*******-Pins & Needles

If you have pain is it CONTINUOUS?
_____

2. Please mark any applications you have tried in the past.
Injections, joint _____ Injections, epidural _____Acupuncture_____
Yoga _____ Chiropractor _____ Ultrasound _____ Massage_____Electrical Stimulation _____ Hot Pack_____ Pain Psychologist_____

3. Please check any positions that aggravate your pain.
Standing _____ Sitting_____Lying down _____
Bending waist _____ Bending, knees_____ Sleep w pillow_____
Walking_____ Bowel Movement _____

4. Do you have control of your bowels and bladder? YES NO

5. Please check any symptoms you have now or have had in the past.

GENERAL	**GENITO-URINARY**	**CARDIOVASCULAR**
_____ Chills	_____ Blood in urine	_____ Chest Pain

_____ Depression
_____ Dizziness
_____ Fainting
_____ Fever
_____ Forgetfulness
_____ Headache
_____ Loss of sleep
_____ Loss of weight
_____ Nervousness

_____ Frequent Urination
_____ Painful urination

MUSCLE/BONE/JOINT

Pain, weakness numbness in:

_____ Arms
_____ Back
_____ Feet
_____ Hands
_____ Hips
_____ Legs
_____ Neck
_____ Shoulders

_____ High Blood Pressure
_____ Irregular heart beat
_____ Poor circulation
_____ Rapid Heart Beat Low
_____ Low Blood Pressure
_____ Ankles swelling
_____ Varicose veins

7. Please check any symptoms you have had within the past 12 months.

GASTROINTESTINAL

____Appetite poor
____Bloating
____Bowl changes
____Constipation
____Diarrhea
____Excessive hunger
____Excessive thirst
____Gas
____Hemorrhoids
____Indigestion
____Nausea
____Rectal bleeding
____Stomach Pain
____Vomiting
____Vomiting blood

EAR, EYE, NOSE, THROAT

____Bleeding gums
____Blurred vision
____Crossed eyes
____Difficulty swallowing
____Double vision
____Earache
____Ear discharge
____Hay fever
____Hoarseness
____Loss of hearing
____Nosebleeds
____Persistent Cough
____Ringing in ears
____Sinus problems
____Vision – flashes or halos

SKIN

____Bruise easily
____Hives
____Itching
____Change in moles
____Rash
____Scars
____Non-healing sores

8. Please check any symptoms you have had within the past 12 months.

MEN

____Breast lump
____Erection difficulties
____Lump in testicles
____Penis discharge
____sore on penis
____Abnormal pap smear
____Bleeding between period
____Breast lump
____Extreme menstrual pain
____Hot flashes

WOMEN

____ Nipple discharge
____ Painful intercourse
____ Vaginal discharge

_____Last GYN exam

9. Please check any conditions you have had within the past 12 months.

____AIDS
____Alcoholism
____Anemia
____Anorexia
____Appendicitis
____Arthritis
____Asthma
____Bleeding D/O
____Breast lump
____Chicken Pox
____Diabetes
____Emphysema
____Epilepsy
____Glaucoma
____Goiter
____Gonorrhea
____Gout
____Heart Disease
____HIV Positive
____Kidney Disease
____Liver Disease
____Measles
____Migraines
____Miscarriage
____Mono
____MRSA
____MS
____Prostate problem
____Psych care
____Rheumatic fever
____Scarlet fever
____Stroke
____Suicide attempt
____Thyroid problem
____Tonsillitis
____Tuberculosis

____Bronchitis	____Hepatitis	____Mumps	____Typhoid fever
____Cancer	____Hernia	____Pacemaker	____Ulcers
____Cataracts	____Herpes	____Pneumonia	____Vaginal infect
____Chemical Dep	____Hi Cholesterol	____Polio	____Venereal Disease

10. Please list any medications or substances to which you have had allergic reactions.

11. List all medications you are currently taking.

Medication	Strength	Quantity per day
_____	_____	_____
_____	_____	_____

12. What is your health goals that you would like Living Well Wellness to assist you with?

_____

_____

I certify that the information I have provided on this health history questionnaire is correct to the best of my knowledge. I will not hold my doctor, Living Well Wellness, its affiliates, officers, directors, employees and contractors responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____
Patient Signature	Date	Living Well Wellness

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