



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 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 HIPAA. 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



HIPAA Privacy Agreement

Due to HIPAA patient privacy regulations I agree to not discuss my treatment with other patients at any time while I am a patient of Living Well Wellness.

Patient Signature: _____ Date: _____





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 carry 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 _____



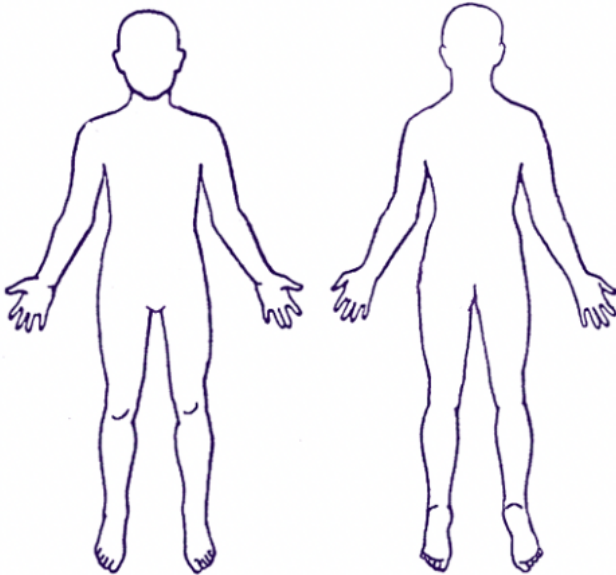
LIVING WELL WELLNESS

BETTER HEALTH THROUGH BETTER LIVING

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 _____ Electri-
 cal 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

- | | | |
|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Fainting | | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Fever | MUSCLE/BONE/JOINT | <input type="checkbox"/> Rapid Heart Beat Low |
| <input type="checkbox"/> Forgetfulness | Pain, weakness numbness in: | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Arms <input type="checkbox"/> Hips | <input type="checkbox"/> Ankles swelling |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Back <input type="checkbox"/> Legs | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Feet <input type="checkbox"/> Neck | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders | |

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

- | GASTROINTESTINAL | EAR, EYE, NOSE, THROAT | SKIN |
|---|--|--|
| <input type="checkbox"/> Appetite poor | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Bowl changes | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Change in moles |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Double vision | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Earache | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Non-healing sores |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Hay fever | |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hoarseness | |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Loss of hearing | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Nosebleeds | |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Persistent Cough | |
| <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sinus problems | |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Vision – flashes or halos | |

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

- | MEN | WOMEN |
|--|--|
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Erection difficulties | <input type="checkbox"/> Bleeding between period |
| <input type="checkbox"/> Lump in testicles | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Penis discharge | <input type="checkbox"/> Extreme menstrual pain |
| <input type="checkbox"/> sore on penis | <input type="checkbox"/> Hot flashes |
| | <input type="checkbox"/> Nipple discharge |
| | <input type="checkbox"/> Painful intercourse |
| | <input type="checkbox"/> Vaginal discharge |
| | <input type="checkbox"/> Last GYN exam |

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

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psych care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mono | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Bleeding D/O | <input type="checkbox"/> Gout | <input type="checkbox"/> MRSA | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> MS | <input type="checkbox"/> Tuberculosis |



- | | | | |
|---------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal infect |
| <input type="checkbox"/> Chemical Dep | <input type="checkbox"/> Hi Cholesterol | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

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

11. List all medications you are currently taking.

<u>Medication</u>	<u>Strength</u>	<u>Quantity per day</u>
<hr/>		
<hr/>		

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