KINGWOOD HEALTH & WELLNESS CLINIC®

REGISTRATION FORM

(Please Print)

Today's date:						PCP:

PATIENT INFORMATION

We verify your identity with your Drivers License

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	DL #	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr. ❑ Business Card	❑ Billboard	❑ Internet
❑ Family ❑ Friend	❑ Newspaper	❑ Yellow Pages	
Other family members seen here:			

Advance Beneficiary Notice of Non-coverage			( )

I hereby certify that the above information is true and correct to the best of my knowledge. I hereby authorize Kingwood Health & Wellness clinic to release any of my patient information required for continued care to other Providers that I may utilize for my care. I understand and agree, that I am financially responsible for any balance owed for my care. Further, I understand that Medicare/Insurance may not cover services rendered and that Clinic Health & Wellness WILL NOT be providing me with any documentation for third party billing/reimbursement purposes, including but not limited to Medicare, Medicaid or Private Pay Insurance. Finally, I understand that the Health & Wellness Clinic WILL NOT be submitting any claims, claim documents or supporting records to any third party on my behalf.

REASON FOR VISIT TODAY

Please check the reason you are coming in today; if it is not listed please write in the reason:

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- ☐ New weight patient
- ☐ Weight follow-up
- ☐ B-complex Injection
- ☐ Lab Consult
- ☐ Lab to be done
- ☐ Office visit
- ☐ Botox Injections
- ☐ Mesotherapy
- ☐ Thyroid Visit

- ☐ Hormone Imbalance
- ☐ High blood pressure
- ☐ Loss of sexual desire
- ☐ Diabetes
- ☐ Headaches
- ☐ Depression
- ☐ Microderm Abrasion

We strive to achieve optimal health & wellness through nutrition, exercise, hormone balance and optimization. Our programs, protocols and philosophy are designed to maximize your QUALITY of life. If your hormone levels are in a "normal" range but are low and you have symptoms we may start therapy to alleviate symptoms. Your telephone number is collected to send appointment reminders as well as clinic specials. You may "opt out" of receiving texts at any time. Please sign below to indicate that you understand and consent to treatment and agree to receive our text reminders.

Patient/Guardian signature *Date*

(Patient MUST read and sign in order to be seen)

KINGWOOD HEALTH & WELLNESS CLINIC®

Original Date:	05/01/2006
Dates Revised:	10/16/13

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	
PERSONAL HEALTH HISTORY		
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List or circle any medical problems that other doctors have diagnosed

☐ Low thyroid	☐ Cancer	☐High Thyroid
☐ High blood pressure	☐ Depression	
☐ High Cholesterol	☐ Bipolar	
☐ Diabetes (insulin or no-insulin)	☐ Reflux	

Surgeries ☐ **No Surgeries Please list or circle if listed**

Year	Surgery	Thyroidectomy ☐R ☐Left ☐Total
	☐ C-section How many?_______________	Gastric ☐ Staple or ☐ Banding
	☐ Hysterectomy ☐ Tubal Ligation	Heart Surgery
	☐ Gallbladder removed (cholecystectomy)	Other:
	☐ Appendectomy	Other:
	☐ Tonsillectomy	Other:

Other hospitalizations

Year	Reason	Age if you do not remember year

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications ☐ **No Known Drug Allergies**	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

PLEASE ANSWER ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting ?			☐ Yes	☐ No
	Have you taken appetite suppressants in the past?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit	☐ Do you desire to quit?______________		

Drugs	Do you currently use recreational or street drugs?	☐ Yes	No
Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father (F)			**Children** (M)male (F)female	☐ M ☐ F	
Mother (M)				☐ M ☐ F	
Diabetes	☐ M ☐ F			☐ M ☐ F	
Heart Disease	☐ M ☐ F			☐ M ☐ F	
Hypertension	☐ M ☐ F		**Grandmother** *Maternal*		
Thyroid	☐ M ☐ F		**Grandfather** *Maternal*		
Kidney	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Do you have problems with weight gain or losing weight?	☐ Yes	☐ No
Do you occasionally feel depressed or have depressed moods?	☐ Yes	☐ No
Is your concentration decreased?	☐ Yes	☐ No
Do you have problems with occasional constipation?	☐ Yes	☐ No
Do you get cold easily or have cold hands or feet?	☐ Yes	☐ No
Have you noticed excessive hair loss?	☐ Yes	☐ No
Is your skin dry?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Poor energy or fatigue?	☐ Yes	☐ No
Bone / Joint Pain	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days Length of periods_______days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____ Miscarriage_______Abortions_____		
Are you pregnant or breastfeeding?	☐ **Yes**	☐ **No**
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ **Yes**	☐ **No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Date of last pap and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)		

Date of last mammogram?___________Results: ☐ Normal ☐ Abnormal (Please list any findings)

MEN ONLY

o you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam? Results: ☐ Normal ☐ Abnormal (Please list any findings)	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Hormonal symptoms