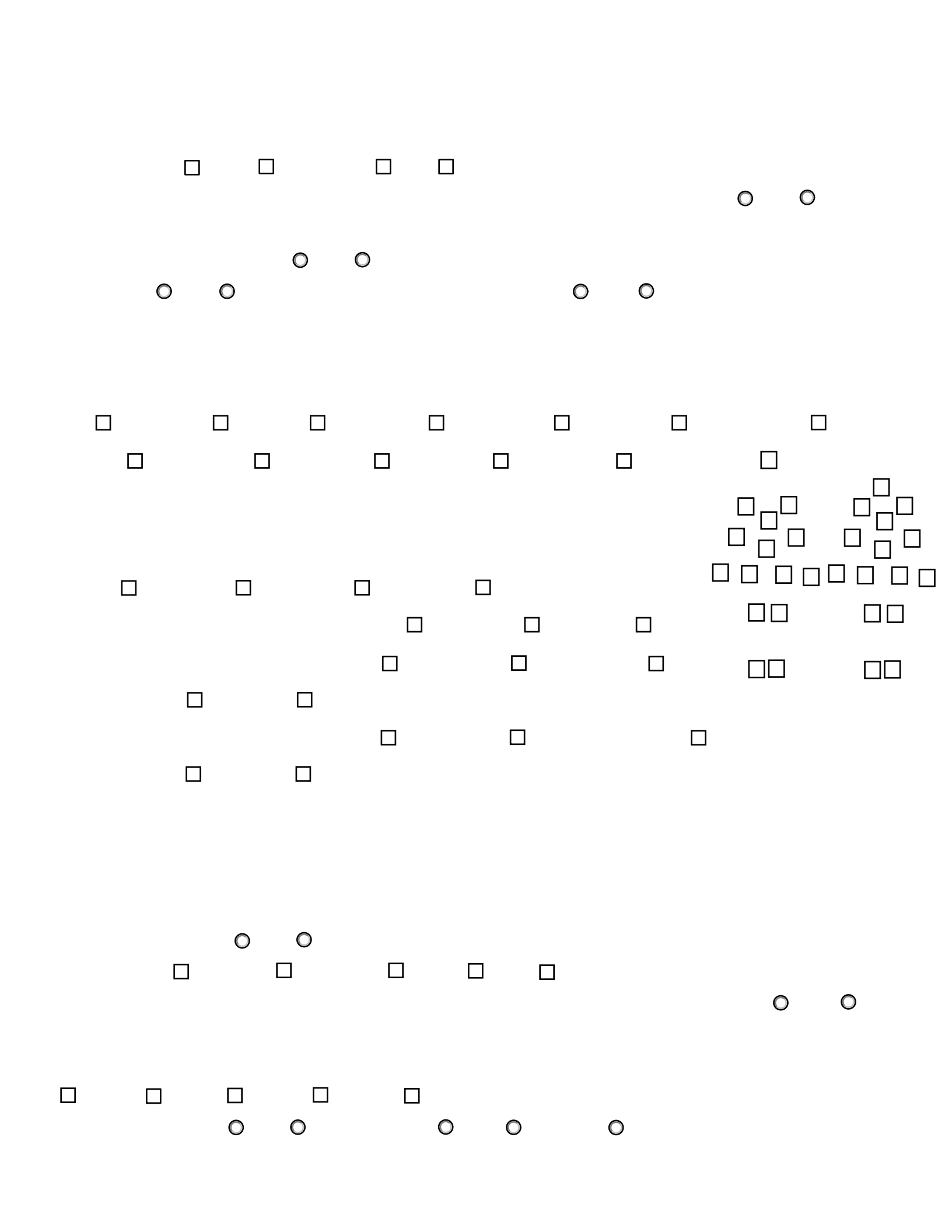
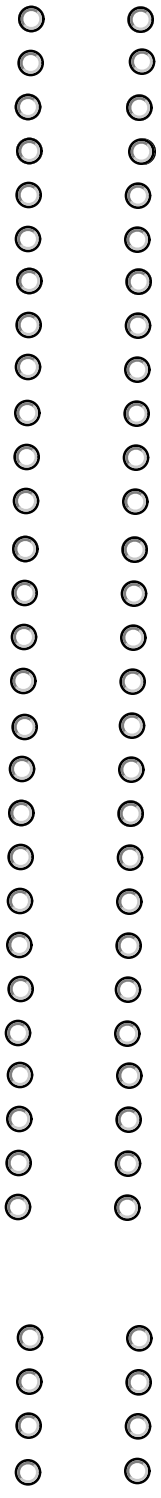
□ □ □ □ □ □





Women Specific

Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____

Menstrual History

Age At 1st Period _____ Menses Frequency _____ Length _____

Painful? ○ Yes ○ No Clotting? ○ Yes ○ No Have you ever missed your period? ○ Yes ○ No

For how long? _____ Are you menopausal? ○ Yes ○ No Age At Menopause _____

Last Menstrual Period _____

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to The Wellness Way Greenville. I authorize The Wellness Way Greenville and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize The Wellness Way Greenville to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a **72 business hour cancellation policy** for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By clicking the submit button below, I agree to the financial policy described above and will adhere to all of its practices.

Please email this completed form to greenville@twwclinics.com.

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

_____

Signature Date

Thank you!

BEYOND LIMITS Health Intervention & Pain Relief Center – A Wellness Way Affiliate
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