LIVING WELL

Health & Wellness Clinic

NEW PATIENT INTAKE & CONSENT PACKET

Whole-person care focused on identifying and treating contributing causes

OUR CARE PHILOSOPHY
Living Well takes a whole-person, root-cause-oriented approach to health. We evaluate symptoms in context and may consider medical history, medications, nutrition, metabolic health, sleep, stress, activity, environment, family history, and other clinically relevant contributors. Our goal is to identify and address medically appropriate underlying contributors whenever possible, rather than relying only on symptom suppression. Prescription medications remain an important part of evidence-based care and may be recommended, continued, adjusted, or discontinued when clinically appropriate. No specific diagnosis, single 'root cause,' cure, or outcome can be guaranteed.

Clinic Information

Living Well	Phone: 479-547-7700
4220 North Crossover Road	Website: nwalivingwell.com
Fayetteville, Arkansas	Care model: Insurance + Cash Pay + Memberships
Owner / Provider: Kyndel Hope Brecheisen, RN, APRN, FNP-BC	Credentials: Holistic APRN	Family Nurse Practitioner - Board Certified

Patient Identification

Legal Name: _____	Preferred Name: _____
Date of Birth: _____	Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to say
Gender identity (optional): _____	Pronouns (optional): _____
Address: _____	Apt/Unit: _____
City/State/ZIP: _____	County: _____
Mobile: _____	Other Phone: _____
Email: _____	Preferred contact: ☐ Call ☐ Text ☐ Email ☐ Portal
Occupation: _____	Employer (optional): _____

Emergency Contact

Name: _____	Relationship: _____
Phone: _____	Alternate phone: _____

Preferred Pharmacy

Preferred pharmacy: _____	Phone: _____
Pharmacy location: _____	City / State: _____

Reason for Today's Visit

Primary concern(s): _____

When did this begin? _____

What do you believe may be contributing to it? _____

What would a successful outcome look like to you? _____

Health Priorities & Goals

List the concerns that matter most to you. Your clinician will use this information together with your medical history, examination, and appropriate testing.

Priority	Concern / Goal	Approx. Start	Impact 0-10

Current Diagnoses / Medical Conditions

☐ High blood pressure ☐ High cholesterol ☐ Diabetes / prediabetes

☐ Thyroid disorder ☐ Autoimmune condition ☐ Heart disease

☐ Asthma/COPD ☐ Kidney disease ☐ Liver disease

☐ Cancer ☐ Neurologic condition ☐ Migraine/headache disorder

☐ Depression/anxiety ☐ Sleep apnea ☐ Chronic pain

☐ GI disorder ☐ Reproductive/hormonal condition ☐ Other

Details / diagnoses / dates: _____

Past Medical Events / Hospitalizations / Surgeries

Condition / Procedure	Date / Year	Facility / Clinician	Outcome / Ongoing Issue

Medication & Supplement History

List prescription medications, over-the-counter medications, vitamins, herbs, hormones, injections, and supplements. Do not stop or change a prescribed medication unless directed by an appropriate prescriber.

Medication / Supplement	Dose	How Often	Reason	Prescriber

Allergies & Adverse Reactions

Medication / Food / Substance	Reaction	Severity / Date

Check if applicable: ☐ No known drug allergies (NKDA) ☐ No known food allergies

Family Health History

Condition	Relative(s)	Approx. Age at Diagnosis
☐ Heart disease		
☐ Stroke		
☐ High blood pressure		
☐ Diabetes		
☐ Thyroid disease		
☐ Autoimmune disease		
☐ Cancer		
☐ Dementia/Alzheimer's		
☐ Mental health disorder		
☐ Substance use disorder		
☐ Clotting disorder		
☐ Genetic condition		

Health Timeline

Birth / childhood health concerns: _____

Major illnesses, injuries, infections, trauma, or life events: _____

Periods when health significantly improved or worsened: _____

Prior testing or treatments that were especially helpful or unhelpful: _____

Nutrition & Metabolic Health

Current eating pattern: ☐ Omnivore ☐ Vegetarian ☐ Vegan ☐ Pescatarian ☐ Low-carb ☐ Gluten-free ☐ Dairy-free ☐ Other

Typical breakfast: _____

Typical lunch: _____

Typical dinner: _____

Snacks / beverages: _____

Water/day: _____	Caffeine/day: _____
Sugary drinks/week: _____	Alcohol/week: _____
Food cravings: _____	Known food triggers: _____

Skip meals? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Shaky, irritable, weak, or fatigued when meals are delayed? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often

Recent significant weight gain/loss (amount and timeframe): _____

Digestive / Gastrointestinal

☐ Reflux/heartburn ☐ Bloating ☐ Gas

☐ Abdominal pain ☐ Constipation ☐ Diarrhea

☐ Alternating constipation/diarrhea ☐ Nausea ☐ Food intolerance

☐ Blood/mucus in stool

Bowel movements/day or week: _____	Bristol stool type if known: _____
History of ulcers/H. pylori: ☐ Yes ☐ No ☐ Unsure	Gallbladder removed: ☐ Yes ☐ No

Prior GI testing: _____

Sleep & Recovery

Average bedtime: _____	Average wake time: _____
Average hours sleep: _____	Time to fall asleep: _____

Usually feel on waking: ☐ Rested ☐ Somewhat rested ☐ Unrefreshed

Check all that apply: ☐ Snoring ☐ Witnessed pauses ☐ Frequent waking ☐ Restless legs ☐ Night sweats

Sleep aids / CPAP / other treatment: _____

Movement, Stress & Daily Environment

Exercise days/week: _____	Minutes/session: _____
Main activities: _____	Sedentary hours/day: _____

Current stress: ☐ Low ☐ Moderate ☐ High ☐ Extreme

Primary stressors: _____

Stress-management practices: _____

Major recent life changes: _____

Environmental & Occupational Exposures

☐ Mold/water-damaged buildings ☐ Smoke/secondhand smoke

☐ Dust/fumes ☐ Pesticides/herbicides

☐ Heavy metals ☐ Industrial chemicals/solvents

☐ Frequent travel ☐ Shift/night work

Occupation and relevant exposures: _____

Home age / water damage / mold concerns: _____

Well water or unusual water exposure: _____

Tobacco, Nicotine, Alcohol & Other Substances

Tobacco/nicotine: ☐ Never ☐ Current ☐ Former	Type/amount: _____
Alcohol: ☐ None ☐ Current ☐ Former	Type/amount per week: _____
Cannabis: ☐ None ☐ Current ☐ Former	Type/frequency: _____
Other substances: ☐ None ☐ Current ☐ Former	Type/frequency: _____

Concerns about dependence, withdrawal, or substance use? _____

Reproductive / Hormonal Health (if relevant)

Last menstrual period: _____	Cycle length/regularity: _____
Pregnant now? ☐ Yes ☐ No ☐ Unsure	Trying to conceive? ☐ Yes ☐ No
Contraception: _____	Menopause? ☐ Yes ☐ No Age: _____
Pregnancies: _____ Births: _____	Miscarriages/complications: _____

Hormone therapy / fertility treatment / reproductive concerns: _____

Review of Systems

Check symptoms you currently experience or have experienced frequently/recurrently. This checklist does not establish a diagnosis.

General: ☐ Fatigue ☐ Fever/chills ☐ Night sweats ☐ Unexplained weight change

Head/Eyes/Ears/Nose/Throat: ☐ Headaches ☐ Vision changes ☐ Hearing changes ☐ Sinus congestion ☐ Sore throat

Cardiovascular: ☐ Chest discomfort ☐ Palpitations ☐ Swelling ☐ Exercise intolerance ☐ Fainting

Respiratory: ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Sleep-related breathing concern

Gastrointestinal: ☐ Heartburn ☐ Bloating ☐ Abdominal pain ☐ Nausea ☐ Constipation ☐ Diarrhea

Genitourinary: ☐ Frequent urination ☐ Urgency ☐ Painful urination ☐ Incontinence ☐ Sexual/reproductive concern

Musculoskeletal: ☐ Joint pain ☐ Muscle pain ☐ Weakness ☐ Stiffness ☐ Back/neck pain

Neurologic: ☐ Dizziness ☐ Numbness/tingling ☐ Tremor ☐ Memory/concentration difficulty ☐ Balance problems

Skin/Hair: ☐ Rash ☐ Itching ☐ Hair loss ☐ Nail changes ☐ Easy bruising

Endocrine: ☐ Heat/cold intolerance ☐ Excess thirst ☐ Blood sugar concerns ☐ Hormonal symptoms

Mental/Emotional: ☐ Anxiety ☐ Low mood ☐ Irritability ☐ Panic symptoms ☐ Sleep disturbance

Immune/Infectious: ☐ Frequent infections ☐ Swollen glands ☐ Slow healing ☐ Recurrent viral symptoms

Immediate Safety Questions

Are you currently experiencing chest pain, severe shortness of breath, stroke-like symptoms, uncontrolled bleeding, or another emergency? ☐ Yes ☐ No

If YES: Call 911 or seek emergency medical care. Do not rely on this form, the portal, text, voicemail, or routine telehealth for an emergency.

Have you had recent thoughts of harming yourself or someone else? ☐ Yes ☐ No

If yes or you are in immediate danger, seek emergency help now. Living Well is not a crisis-response service.

Records, Testing & Prior Care

May Living Well request relevant records from other healthcare providers after obtaining any authorization required by law? ☐ Yes ☐ No

Records most important to obtain: _____

Recent labs/imaging and dates: _____

Previous treatments that helped: _____

Treatments that caused problems or side effects: _____

Patient Care Preferences

Understanding contributing causes is: ☐ Very important ☐ Somewhat important ☐ Not important

Open to discussing: ☐ Lifestyle ☐ Nutrition ☐ Medication ☐ Supplements ☐ Procedures ☐ Referral/specialist care

Treatments or approaches you prefer to avoid: _____

Religious, cultural, accessibility, or communication considerations: _____

Living Well Care Philosophy Acknowledgment

☐ I understand Living Well uses a whole-person, medically informed approach and may consider lifestyle, nutrition, sleep, stress, environment, family history, medications, and other clinically relevant factors.

☐ I understand that symptoms can have multiple causes and that no clinician can guarantee that a single root cause exists or can be identified.

☐ I understand that Living Well is not anti-medication. Medications may be recommended when clinically appropriate, and medication prescribed by another clinician should not be stopped or changed without appropriate medical guidance.

☐ I understand recommendations may include conventional testing or treatment, lifestyle or nutrition interventions, supplements, functional/advanced laboratory testing, imaging, referrals, or other interventions within the provider's scope and clinical judgment.

☐ I understand some services, tests, supplements, or treatments may not be covered by insurance and that I may ask about cost and alternatives before proceeding.

Patient initials: _____

Consent for Evaluation and Treatment

I voluntarily consent to evaluation and treatment by Living Well's licensed APRN. Care may include medical history, examination, clinical assessment, ordering/reviewing laboratory tests or imaging, medication management, health counseling, referrals, and other services within the APRN's lawful scope of practice. I understand medicine is not an exact science and no guarantees have been made regarding diagnosis, treatment response, or outcome. I may ask questions and may decline a recommended non-emergency service. Separate informed consent may be required for specific medications, procedures, laboratory tests, telehealth, or other services.

Accuracy of Information & Patient Responsibilities

☐ I certify that the information I provide is accurate and complete to the best of my knowledge.

☐ I will update Living Well about material changes in my health, medications, allergies, pregnancy status, insurance, or contact information.

☐ I understand incomplete or inaccurate information may affect clinical decisions.

☐ I understand Living Well is not an emergency service and urgent or emergency symptoms require appropriate emergency care.

Financial Responsibility / Insurance / Cash Pay / Membership

Living Well uses a combination of insurance billing, cash-pay services, and membership services. Insurance participation and coverage vary by plan and service. Verification of benefits is not a guarantee of payment. I am financially responsible for copayments, coinsurance, deductibles, non-covered services, cash-pay services, membership fees, and other patient-responsibility amounts permitted by law and applicable agreements. Membership services do not constitute health insurance and do not guarantee that outside medical services, laboratory work, medications, imaging, emergency care, or specialist care are included unless expressly stated in the membership agreement.

Expected payment arrangement: ☐ Insurance ☐ Cash pay ☐ Membership ☐ Combination

I received or was offered the applicable financial / membership policy. ☐ Yes ☐ No ☐ Not applicable

Applicable membership / plan name: _____

Insurance Claims Authorization (if applicable)

When Living Well bills my health plan, I authorize the clinic to submit claims and disclose information reasonably necessary for payment and healthcare operations as permitted by law. I authorize payment of benefits to Living Well when assignment is permitted by my health plan and applicable law.

Arkansas Telehealth Consent

Living Well offers telehealth for clinically appropriate services. Telehealth may use live interactive audio-video technology and, when permitted, other modalities that meet Arkansas requirements. Telehealth is not appropriate for every condition and may be converted to an in-person visit or referral when the provider determines that an adequate evaluation cannot be completed remotely.

☐ I understand telehealth is held to the same applicable standard of care as an in-person encounter and the provider must practice within the scope of her Arkansas APRN license.

☐ I understand a professional patient-provider relationship must be established in a manner permitted by Arkansas law and APRN rules; completing an online history form by itself may not be sufficient.

☐ I understand potential limitations include technology failure, incomplete physical examination, limitations in diagnostic information, privacy/security risks, and the possibility that an in-person examination, testing, emergency evaluation, or referral will be recommended.

☐ I will tell the provider my physical location at the start of a telehealth encounter and provide an emergency contact when requested.

☐ I understand telehealth is not for emergencies. For a medical or psychiatric emergency I will call 911 or seek emergency care.

☐ I understand prescriptions through telehealth are subject to federal and Arkansas law and APRN prescribing rules; a telehealth visit does not guarantee that a medication will be prescribed.

☐ I consent to Living Well documenting the telehealth encounter in my medical record and to the use of reasonable privacy and security safeguards.

☐ I understand I may withdraw consent to future telehealth care and request an in-person visit, subject to clinical availability and medical necessity.

Telehealth choice: ☐ I consent to telehealth ☐ I decline telehealth at this time

Patient initials: _____

Care Coordination Following Telehealth

If clinically appropriate, I consent to Living Well sending a record of a telehealth encounter to my regular treating clinician as permitted by law. ☐ Yes ☐ No ☐ Not applicable

Regular treating clinician / practice: _____

Weight-Management Services - General Acknowledgment

Living Well may offer weight-management evaluation and treatment. Treatment may include nutrition/activity counseling, review of medical contributors, laboratory testing, behavioral strategies, and, when clinically appropriate and legally permitted, prescription medication. Weight-management medications have medication-specific indications, contraindications, warnings, side effects, monitoring requirements, and risks. This general intake acknowledgment does not replace medication-specific informed consent or prescribing counseling.

□ I understand weight change is affected by multiple medical, behavioral, genetic, environmental, and medication-related factors and results cannot be guaranteed.

□ I will disclose pregnancy, attempts to conceive, breastfeeding, eating-disorder history, relevant gastrointestinal conditions, pancreatitis/gallbladder history, endocrine conditions, and all medications/supplements as requested.

□ I understand laboratory monitoring, follow-up visits, dose adjustments, or discontinuation may be required for safety or effectiveness.

□ I understand insurance may not cover weight-management medications, laboratory testing, or related services.

Patient initials: _____

Supplements / Nutraceuticals

Living Well may discuss vitamins, minerals, herbs, nutraceuticals, or other supplements when clinically appropriate. Supplements can cause side effects, allergic reactions, drug interactions, laboratory-test interference, or other harms. Product quality and evidence vary. “Natural” does not mean risk-free. I agree to provide a complete list of supplements and medications and to notify Living Well of adverse effects.

I understand that supplements may be recommended but are not guaranteed to diagnose, treat, cure, or prevent a specific disease. □ Yes □ No

Patient initials: _____

Functional / Advanced Laboratory Testing

Living Well may offer conventional and functional/advanced laboratory testing when the provider believes it may contribute useful clinical information. Some advanced tests may have limited insurance coverage, may be processed by outside laboratories, and may have varying levels of clinical validation or utility for a particular condition. Results must be interpreted in the context of the full clinical picture and do not automatically establish a diagnosis or treatment plan.

□ I understand I may ask why a test is being recommended, how the result may affect care, whether alternatives exist, and what the estimated patient cost is before testing.

□ I understand laboratory charges may be billed separately by an outside laboratory and may be my responsibility if not covered by insurance.

□ I understand abnormal or uncertain findings may require confirmation with standard laboratory testing, imaging, specialist evaluation, or other follow-up.

Patient initials: _____

Electronic Communications Consent

Living Well may use telephone, voicemail, patient portal, text message, or email for appointment and administrative communications. Electronic communications can carry privacy risks. Sensitive clinical information should generally be exchanged through secure methods selected by the clinic. Do not use routine text, email, or voicemail for emergencies.

I authorize contact by: ☐ Portal ☐ Phone ☐ Voicemail ☐ Text/SMS ☐ Email

Restrictions / special instructions: _____

May messages identify the clinic as Living Well? ☐ Yes ☐ No

May detailed voicemail messages be left? ☐ Yes ☐ No

HIPAA Notice of Privacy Practices - Acknowledgment

I acknowledge that I was provided, offered, or given access to Living Well's Notice of Privacy Practices, which describes how protected health information may be used or disclosed and explains patient privacy rights. This acknowledgment is not a HIPAA authorization for uses or disclosures that require a separate authorization.

Notice status: ☐ Paper copy ☐ Electronic copy/access ☐ Offered copy ☐ Declined copy

Patient / representative initials: _____

Optional Communication With Designated Person(s)

This section records routine communication preferences. Living Well may require a separate HIPAA authorization for disclosures that legally require one.

Name	Relationship	Phone	Information permitted

Release / Request of Records

A separate authorization may be required before Living Well obtains or releases records when authorization is required by federal or Arkansas law. Sensitive categories of information may require additional protections or specific authorization.

Patient Acknowledgments & Signatures

By signing below, I confirm that I reviewed the sections of this packet that apply to me, had the opportunity to ask questions, and consent to the care and communications I selected. I understand additional service-specific forms may be required. I understand that signing this intake packet does not waive legal rights that cannot lawfully be waived.

Patient name (print): _____

Patient signature: _____

Date: _____

Time: _____

Parent / guardian / legal representative (if applicable): _____

Relationship / authority: _____

Representative signature: _____

Date: _____

Clinic Compliance Note

This packet is designed as a general Arkansas-oriented clinical intake and consent template. Living Well should have Arkansas healthcare counsel and the clinic's compliance professional review it before implementation and whenever services, prescribing practices, payer contracts, membership terms, privacy practices, or applicable law change. Medication-specific, procedure-specific, telehealth, laboratory, privacy, and membership documents should be maintained separately when required.