MY HEALTHY BLUEPRINT WELLNESS VISIT

PROVIDER TO FAX TO: 850.908.9030

PATIENT DEMOGRAPHICS TO BE COMPLETED BY PATIENT:

First Name:_____ Last Name:_____ Date of birth:_____

Phone: _____ Employee ID of BHC/LCI employee that carries the health insurance: _____

INFORMATION BELOW MUST BE COMPLETED BY MEDICAL PROVIDER:

Height:	Waist Measurement (at umbilical):	BMI:
Weight:	Height to Waist Ratio:	Blood Pressure:

Place a check in the box that best describes the current health status of this patient. ONLY CHECK ONE.	
	Patient is healthy, with no significant risk factors.
	Patient is healthy, but at risk for a chronic disease or has other significant risk factors.
	Patient has one or more chronic diseases with significant risk factors, but is stable or at desired treatment goal.
	Patient has one or more chronic diseases with significant risk factors, and is not at desired treatment goal.
	Patient has multiple chronic diseases, significant risk factors, complications and/or complex treatment(s).
	Patient has complex condition in which his/her health may or may not be restored.

NOTES:

Physician's Name (print): _____ Date of Visit: _____

Physician's Name Signature:_____ Physician's Office Number: _____