HealthStrong Integrative Medicine, PLLC

53 Bay Street, Ste. 1
Manchester NH 03014
(603)-260-1545

Last ______________________________ First Name ____________________

STREET ADDRESS ____

City__________________________ST________________ Zip ______

PHONE (H) ______________ (W) ______________ Mobile____________________

Please circle the number you would like to be reached at above.

Is it alright to leave messages regarding your medical care at: Home [ ] Work [ ] Cell [ ]

BIRTHDATE________AGE________ SS#____________________ Sex_________

HEIGHT ____________WEIGHT______________

Who referred you? ____

Would you like a free E-News letter emailed to you on a quarterly basis? Y / N

If Yes Email ____

Occupation _________________________ Hours per week _________ Retired _____

Employer ____

Primary Care Doctor Information

Name: ____

Address:____

City: ____________________________ State:__________ Zip:__________

Telephone:______________________ Fax: ___________________________

Married _____ Separated _____ Divorced _____ Widowed _____ Single ____________ Partnership ________

Live with: Spouse _____ Partner _ Parents _____ Children _______ Friends ____ Alone _______

Do you have any children? YES NO Please list their age(s) ______________________________

How did you hear about HealthStrong Integrative Medicine? ______________________________

Have you ever consulted a Naturopathic Doctor, Nutritionist, or other alternative medicine provider before?_______________
____

Please indicate your primary health concerns below (in order of importance) and indicate how these problems limit you.

1) ____

2) ____

3) ____

Date of last physical/annual exam: ____________________ **Date of last blood tests:** __________________________

List all past medical conditions, surgeries & hospitalizations, including date occurred:

Medical Condition	**Date of Surgeries/ Hospitalizations**	**Date of Onset**

Please list all medications you are taking:

Current Medications: Pharmaceuticals (Rx and Over the counter), contraceptives			
Medication/Supplement name	**Dose**	**Frequency**	**How long?**

Please list all supplements you are taking:

Current Medications: Herbs, vitamins, etc.			
Supplement name	**Dose**	**Frequency**	**How long?**

Did you receive all the recommended childhood vaccinations? Other Vaccinations?

____

____

Please indicate below all known medical conditions in your family.

Mother ______________________________ Father_________________________

Siblings ______________________________ Paternal Grandmother ____________________

Maternal Grandmother ___________________ Paternal Grandfather _____________________

Maternal Grandfather ___________________ Uncles ___________________________

Aunts ______________________________ Other ___________________________

Do you exercise regularly? YES NO What type? ______________________________________

How long? ___________________ How often? __________________________________

Hobbies: ____

Please tell us a little bit about your sleep habits.

How long per night? ____________________ If you wake up frequently, what is the reason? ___________________________________

Do you wake up refreshed? ____________ Do you take naps? ________________

Social History

Where did your grow up?____________________ List other places you have lived____

HABITS				
SUBSTANCE	CURRENT	PAST	NEVER	FREQUENCY
Alcohol				
Caffeine				
Tobacco				
Marijuana				
Other Recreational Drugs				

What do you do for work?______________________________________Do you enjoy your job? ___________

Do you have an active spiritual practice? ___________

Do you have history of sexual, mental/emotional, physical abuse? ____

How committed are you towards making valuable changes: Little Moderately Very

Toxin Exposure

Do you have any known excessive exposure to the following? Circle any or all below that apply.

Solvents Heavy Metals Fumes

Excessive pollution Leaded paint Toxic Materials

Are you particularly sensitive to any of the following? Circle any or all below that apply.

New carpeting Perfumes Gasoline Other vapors

If you answered yes above what happens when you are exposed to them?____

Do you use pesticides, herbicides or other chemicals around your home? ____

Coffee (ounces per day): ______________________________ Soda Pop (ounces per day):_________________________________

Water intake (ounces per day)__________________________ Other beverages (please indicate):____________________________

Typical Day's Diet

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Do you follow any particular diet regimens of restrictions? If yes, please describe:

____

Do you have any allergies (medications, foods, topicals, etc) that are severe or life threatening: YES NO

If yes, please describe: ____

Rate your energy level from 1-10: __________________

Stress level from 1-10 (10 is very high stress):____

Maximum adult weight: _________ **Minimum adult weight**____________ **Current weight**__________

Please list your dental history (including extractions, fillings, frequency of cleanings)

Please circle all signs and symptoms that you experience now or have experienced in the past.

Please write "N" above the sign/symptom if you are experiencing it now (within the last 1-2 weeks):

General: Fevers, chills, sweats, anorexia, fatigue, malaise, weight loss, cancer, decreased appetite, problems sleeping.

Head: Head injury, frequent headaches, migraines, other types of headaches, gum disease, silver amalgams,

Eyes: Blurring, double vision, irritation, discharge, vision loss, eye pain, sensitive to light, glaucoma, cataracts.

Ears: earache, ear discharge, ringing in the ears, decreased hearing, frequent ear infections

Nose: Nasal congestion, sinus congestion, nasal polyps, nosebleeds, frequent runny nose, frequent itchy nose

Throat: Sore throat, hoarseness, difficulty swallowing.

Cardiovascular: High blood pressure, low blood pressure, angina, heart attack, heart murmur, valve disease, chest pains, palpitations, fainting, difficulty in breathing on exertion, difficulty breathing when lying down, sudden shortness of breath when sleeping, edema

Respiratory: Cough, difficulty breathing, excessive sputum, bloody sputum, wheezing, asthma, emphysema

Gastrointestinal: Heartburn, stomach ulcer, gastric bleeding, nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, black stools, bloody stools, jaundice, gastritis, hemorrhoids, belching, flatulence, abdominal bloating

Genitourinary: Kidney disease, hepatitis, vaginal discharge, incontinence, painful or difficult urination, blood in the urine, urinary frequency, weak urine stream, amenorrhea, excessive menstrual flow, abnormal vaginal bleeding, pelvic pain, urinary tract infections.

Musculoskeletal: Back pain, neck pain, limb pain, arthritis, muscle pain, muscle spasms, muscle cramps, morning stiffness

Skin: Rash, itching, dryness, psoriasis, eczema, hives, moles that have changed.

Neurologic: Transient paralysis, weakness, symptoms of numbness, prickling or tingling, seizures, fainting, tremors, dizziness.

Psychiatric: Depression, anxiety, memory loss, mental disturbance, suicidal ideation, hallucinations, paranoia, addiction, foggy Thinking, seasonal depression, excessive irritability, excessive anger

Endocrine: Diabetes, cold intolerance, heat intolerance, excessive thirst, excessive hunger, excessive urination, weight change.

Heme/Lymphatic: Abnormal bruising, bleeding, enlarged lymph nodes.

Allergic/Immunologic: allergic skin rashes, hay fever, persistent infections, frequent infections, HIV exposure, poor wound healing, food allergies, chemical sensitivities

Female: endometriosis, PCOS, infertility, dyspyrunia, menopausal sx, PMS, cervical dysplasia, abnormal PAP, vaginal discharge, breast discharge, irregular menstruation, clotting.

HealthStrong Integrative Medicine, PLLC.

Consent for Treatment

Consent for Purposes of Treatment, Payment, and Health Care Operation

I consent to the use of disclosure of my identifiable health information by the HealthStrong Integrative Medicine, PCCL for the purposes of diagnosis or provising treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that my diagnosis or treatment by the practitioners at HealthStrong Integrative Medicine, PLLC may be conditioned upon my consent as by my signature on this document. Practitioner means a Naturopathic Doctor, Acupuncturist, Medical Doctor, Chiropractic Doctor, Osteopathic Doctor, Massage Therapist or other healthcare worker employed by or under contract with the HealthStrong Integrative Medicine, PLLC.

Patient means any person seeking the health care advice and/or treatment of a practitioner at the HealthStrong Integrative Medicine, PLLC through consultation by phone or in person.

My identifiable health information means health information collected from me and created or received by my practitioner, another health care provider, a health plan, and my employer. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. HealthStrong Integrative Medicine, PLLC is not required to agree to the restrictions that I may request. However, if the HealthStrong Integrative Medicine, PLLC agrees to a restriction that I request, the restriction is binding upon the HealthStrong Integrative Medicine, PLLC. I have the right to revoke this consent, in writing, at any time except to the extent that the HealthStrong Integrative Medicine, PLLC has taken action in reliance of this consent.

I understand that I have the right to review the HealthStrong Integrative Medicine, PLLC Notice of Privacy Practices prior to signing this document. This notice describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of HealthStrong Integrative Medicine, PLLC.

HealthStrong Integrative Medicine, PLLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices at any time by requesting the most current notice in writing or in person at the time of my office visit.

Emergency Care:

Our clinic does not administer emergency medical care. In the case of an emergency, please see your family physician or the emergency room of the nearest hospital. After emergency care has been administered, patients often respond well to Naturopathic care to accelerate the healing process.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, and American Express.
We are currently able to bill some insurances in the states of New Hampshire.

- •Upon request, an invoice can be produced which may be submitted to insurance companies for reimbursement by the patient. Please ask for this invoice at time of payment.
- •The HealthStrong Integrative Medicine, PLLC does not guarantee reimbursement by the patient's insurance company.
- •I understand that it is not the responsibility of the HealthStrong Integrative Medicine, PLLC to research whether reimbursement may occur, to submit forms for reimbursement, or to follow up with my insurance company regarding reimbursement.

Cancellation Policy:

The HealthStrong Integrative Medicine, PLLC requires at least 24 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without notification will be charged the full visit fee. Cancellations with less than 24 hours notice will be billed 50% of the visit fee.

- •I agree to pay for services rendered at time of service. I acknowledge that I may request the fees for various procedures before they occur and include that information in my decision regarding healthcare.
- •I am aware that my practitioner may charge for telephone consultations.
- •I understand that this office requires notice of cancellation at least 24 hours in advance of the scheduled appointment time.
- •I consent to treatment as agreed upon between the practitioner and myself. Any therapy will proceed only with our mutual consent. I agree to discuss any problems in my care with the practitioner.

_______________________________________ ________________
Signature of Patient or Authorized Representative Date

____
Printed name and relationship to patient