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_____

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

If yes, please describe: _____

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? _____

Who referred you? _____

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) _____

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

Medical Condition	Date of Surgeries/ Hospitalizations	Date of Onset

Date of last physical/annual exam: _____ Date of last blood tests: _____

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 (please be SPECIFIC)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you follow any particular diet regimens of restrictions? 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, loss of smell

Throat: Sore throat, hoarseness, difficulty swallowing, loss of taste

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, painful intercourse, menopausal sx, PMS, cervical dysplasia, abnormal PAP, vaginal discharge, breast discharge, irregular menstruation, clotting.

Male: difficulty getting erection, difficulty maintaining erection, painful intercourse

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:

The Doctor does not carry a pager or take calls on her cell phone. Dr. Beaudoin does not provide any emergency or after-hours services. It is recommended you maintain a relationship with a Primary Care Provider, in case you have urgent or after-hours needs.

Payment:

Payment is expected in full at time of service. We accept personal checks, cash, Visa, Mastercard, HSA/FSA and American Express. There is a $25 fee for returned checks.
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 48 hours notice of cancellation in advance of the scheduled appointment time. Missed appointments without 48 hours notification will be charged $75.

- 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 understand that this office requires notice of cancellation at least 48 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