



CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Date: _____

Email Address: _____

Birth Date: _____ Male: _____ Female: _____ Birth Gender (circle): M F

Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: () _____ Cell Phone #: () _____

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

How did you hear about our office? _____

Appointment Reminders? Voice Home Voice Cell Text Email None

Present Symptom(s) that you have: _____

When Symptoms Started _____ How Symptoms Started _____

Severity of Pain from 1 (mild pain) to 10 (severe pain) _____

What is your pain/condition holding you back from doing (ie. Sleeping, exercising, traveling)?

What relieves your symptoms? _____

What makes your symptoms worse? _____

At what time in your life did you feel your best? _____

Please list all **known DRUG and FOOD allergies**:

Drug Name and/or Food:	Reaction:
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_____	_____
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_____	_____
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_____	_____
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List ALL medications & supplements you take (prescription & over the counter)

Table with 3 columns: Drug Name, Dosage, How long have you taken & for what conditions? with multiple rows for input.

Check ALL medical conditions that you may have had or currently have now:

- List of medical conditions with checkboxes: ADD/ADHD, Depression, Hepatitis, Miscarriage, Alcoholism, Diabetes, High Blood Pressure, Multiple Sclerosis, Allergy, Eczema, High Cholesterol, Parkinson's, Alzheimer's, Emphysema, High Blood Sugar, Pneumonia, Anemia, Epilepsy/seizures, HIV/AIDS, Raynaud's, Appendicitis, Fibromyalgia, Irritable Bowel, Rheumatoid Arthritis, Asthma, Gall Bladder, Kidney Infect./stones, Ringing in ears, Arthritis, Goiter, Low Blood Pressure, Sinus Infection, Cancer, Gout, Low Blood Sugar, Stroke, Celiac Disease, Heart Attack, Lyme Disease, Thyroid Problems, Chronic Fatigue, Heart Disease, Lupus, Ulcers, Migraine, Vertigo/Dizziness

Other: _____

Please list all previous surgeries & dates:

Two horizontal lines for listing previous surgeries and dates.

Alcohol use? Yes / No Amount _____ Daily / Weekly / Socially

Tobacco use? Yes / No PPD _____ How many years? _____



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Please check all symptoms that you currently have:

- Fatigue
- Aches & Pains
- Cold hands & feet
- Decreased sweating
- Excessive sweating
- Need excessive sleep
- Weight Gain
- Depression
- Losing scalp hair
- Dry skin
- Mental Slowness
- Constipation
- Diarrhea/IBS
- Acne
- Back Pain
- Frequent nausea
- Heart palpitations or rapid rate
- Nervousness, anxiety or panic attacks
- Weight loss, can't gain weight
- Difficulty falling asleep
- Difficulty staying asleep
- Hypoglycemia, must eat frequently
- Frequent colds and other infections
- Low blood pressure, light headedness
- Low tolerance for stress, slow recovery
- Salt cravings
- Sugar cravings

Females Only:

- Date of last period _____
- Heavy blood flow
- Irregular periods
- Breast swelling, tenderness or cysts
- PMS
- Swelling of face, fingers or ankles
- Infertility
- Hot flashes or night sweats
- Moodiness, cries easily
- Painful intercourse
- Vaginal dryness, pain or itching
- Dry or irritated eyes
- Disinterest in sex
- Facial hair growth
- Currently pregnant
- Current or past hormone therapy:

Males Only:

- Apathy, low motivation
- Decreased physical stamina
- Loss of muscle mass or strength
- Joint stiffness
- Moodiness, irritability
- Decrease in libido
- Few or no spontaneous AM erections
- Prostate enlargement
- Increased fat around waist and hips



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Please list your top 3 major health concerns in order of importance:

- 1. _____
- 2. _____
- 3. _____

AUTHORIZATION & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes _____ No _____

I fully understand that my signature is consent and authorization to be examined by the Center for Wellbeing medical team.

Patient Signature _____ Date _____



Cancellation and No Show Policy

We understand that situations arise in which you must cancel your scheduled appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. Appointments which are cancelled within less than 24 hour notice may be subject to pay the full balance owed at the time of cancellation. Cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that unavoidable circumstances may cause you to cancel with less than a 24-hour notice, fees may be waived upon management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and no show fees can be directed to the front desk at (603) 380-9159.

Please sign that you have read, understand and agree to this cancellation and no show policy.

Patient Name (Please Print) Date

Signature of Patient Date