CENTER FOR WELLBEING®

CONFIDENTIAL PATIENT INFORMATION

Full Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

Email Address: _____

Birth Date: _____ Sex: M F Birth Gender (circle): M F

Race (ie: White, Asian, African American): _____ Hispanic or Latino: ___Yes ___No

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced

Name of Emergency Contact: _____Phone: _____

Relationship to Patient: _____

Primary Care Physician: _____Phone:_____

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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List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

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

__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 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:

_____

_____

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

Tobacco use? Yes / Never / Former Smoker 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 HIPPAA 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

Authorization to Disclose Medical Records and Health Information

Patient Name:_____

Date of Birth:_____ Phone:_____

Records Release To:

Provider/Clinic/Organization:_____CENTER FOR WELLBEING_____

Bedford Office:
Address:18 Constitution Drive Suite 2, Bedford, NH 03110 **Phone**: 603-472-6192 **Fax**: 603-472-6196

Portsmouth Office:
Address: 3201 Lafayette Road, Portsmouth, NH 03801 **Phone**: 603-380-9159 **Fax**: 603-427-8290

I hereby authorize the release of my medical records to the designated provider listed above.

Please Initial

_____ Complete Medical Record

Patient Signature:_____ Date:_____