BLUEZONEHEALTHNH.COM
P: 603-880-4150
F: 603-880-6765

BLUE ZONE HEALTH

29 RIVERSIDE STREET
UNITS A & B
NASHUA, NH 03062

MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

Welcome to Our Blue Zone Health Family! **Your Health History is very important to us. Please fill out this form COMPLETELY.**		
Today's Date:		
Patient Title: ☐ Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.		
Legal First Name:	Legal Last Name:	
What do you prefer to be called?:		
Street Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
Would you like us to send you a text message for your future appointment reminders? ☐ **Yes, text please!** ☐**No, thank you. No Reminder needed.**		
Email:		
Would you like to be added to our mailing address? ☐ Yes, please! ☐No, thank you.		
Date of Birth: / /	Age:	Sex: ☐ Male ☐ Female ☐Other_____
Marital Status: ☐Single ☐Married	Spouse's Name:	
Are you/Is it possible you're pregnant? ☐ Yes ☐No	Est. Date of Delivery : / /	
Are you or your spouse trying to become pregnant? ☐Yes ☐ No	# of Children:	
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
☐ Please do not share results of my visits with this provider		
Who may we thank for referring you?		

What is your approximate…	Height: _____'_____"	Weight: _____lbs.

Employment Status		
What is your job title/occupation?:		
☐Employed Full-Time	☐Employed Part-Time	☐Retired
☐Student	☐Work From/At Home	☐ Self- Employed
Employer Name:		

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Consent to Treat and Bill

By signing below, I understand that I hereby authorize Blue Zone Health (hereafter "BZH") to disclose my medical information for the purpose of treatment, payment, healthcare operations and coordination of care. I understand that I am responsible for payment in full of all charges. I request that payment of authorized Medicare and other insurance benefits be paid directly to BZH. I also authorize BZH to release all information necessary for the processing of insurance claims to Health Care Financing Administration (HFCA), its agents or any other insurance company to determine the benefits payable for related services. I understand that if I refuse to sign this consent for the purpose of treatment, payment and health care operations, the healthcare provider has the right to refuse to give care.

I understand that by authorizing this release of my medical records I also release BZH from all legal responsibility or liability that may arise from the release of these medical records. This authorization is valid until further notification to the contrary.

I acknowledge that I have been made aware of the privacy policy of this office, as it pertains to the privacy and confidentiality of my medical records. If I would like to have a more details concerning the privacy of my Patient Health Information I can ask to read the HIPPA NOTICE that is available to me at the front desk before signing this consent.

HIPAA Disclosure

In an effort to maintain patient confidentiality and the guidelines within the HIPAA regulations, please fill out this section in regards to having someone other than you obtain information regarding upcoming appointments and/or information from your medical record.

☐ I give permission to the following family/friend:

Name: _____ Relation: _____ Ph #:_____

☐ I decline to give permission to a family member/friend.

Signature of Patient/Guardian: _____ **Date:** _____

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Why are you seeking care with us? ☐**Pain** ☐**Wellness** ☐**Nutrition/Lifestyle**	
What area(s) of your health are you concerned about?	
When did your symptoms start?	
Have you missed work due to this condition?	☐ No ☐ Yes How Long?
Have you had any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done? Where?
Have you been to a chiropractor before?	☐ No ☐Yes Name/Office:
Have you ever had a professional massage before?	☐ No ☐Yes Name/Office:

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Please check the following boxes if you HAVE OR HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐No issues	☐No issues	☐No issues	☐ No issues
☐High blood pressure	☐Reflux/Heartburn	☐Thyroid Issues	☐Skin Cancer
☐Low Blood Pressure	☐Ulcer	☐Immune Disorders	☐Psoriasis
☐High Cholesterol	☐Constipation	☐Frequent Infections	☐Eczema
☐Poor Circulation	☐Diarrhea	☐Hypoglycemic	☐Acne
☐Fainting	☐Food Sensitivities	☐Diabetic Type I ☐ Type II ☐	☐Rash
☐Angina/Chest pain	☐Anorexia/Bulimia	☐Swollen/hard glands	☐Other
☐Excessive Bruising	☐Poor appetite	☐Low Energy	
☐Palpitations	☐Other	☐High stress	
☐Other		☐Low Libido	
		☐Fatigue	
		☐Other	

Genitourinary	**Musculoskeletal**	**Neurological**	**Respiratory**
☐No issues	☐No issues	☐No issues	☐No issues
☐Kidney Stones	☐Upper back Pain	☐Sciatica	☐Asthma
☐Prostate Issues	☐Mid-back Pain	☐Pins and Needles	☐Apnea
☐Erectile dysfunction	☐Low back Pain	☐Numbness	☐Persistent cough
☐Bedwetting	☐Neck Pain/Stiffness	☐Dizziness	☐Difficulty breathing
☐Recurrent UTI	☐Headaches	☐Tremors	☐Hay fever
☐Infertility	☐Migraines	☐Blurred Vision	☐Emphysema
☐Ovarian Cysts	☐Osteoporosis	☐Carpal Tunnel	☐Pneumonia
☐PMS symptoms	☐Arthritis	☐ Anxiety	☐Bronchitis
☐Other	☐Arm/hand pain	☐Depression	☐Other
	☐Shoulder problems	☐Irritability	
	☐Plantar Fasciitis	☐Visual Disturbances	
	☐Foot/ankle pain	☐Loss of balance	
	☐Leg pain	☐Blurred Vision	
	☐Hip problems	☐Loss of taste	
	☐TMJ issues	☐Loss of smell	
	☐Scoliosis	☐Bell's Palsy	
	☐Poor Posture	☐Loss of hearing	
	☐Other	☐PTSD	
		☐Other	

Are there any past or current medical conditions you have not told us about?

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Health History		
Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. ☐ If NO current medications please check here.		
Medication/Supplement	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
Please list any known allergies you may have. ☐ If no known allergies, check here.		
1.	2.	
3.	4.	

Hospitalizations, Surgeries, and Injuries/Accidents **Please date/list reasons for any hospitalizations or surgical procedures.**	
Date	Reason
Please describe any other injuries/accidents not mentioned previously.	
Date	Injury

Family History Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)	

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Lifestyle Habits	
Any major stressors in your life? If so, what are they?	
Do you see any health specialists? If so, what type, and for what?	
Do you see a dentist regularly? Last visit?	
Do you see an eye doctor routinely? Last visit?	
How much and how often do you drink alcohol?	#_____Drinks, ☐Daily ☐Weekly ☐Monthly
How many cups of coffee/caffeine do you drink daily?	#_____ Cups
How much soda do you consume daily?	#_____Cups
How much water do you drink daily	#_____Cups
Do you use recreational drugs?	☐Yes ☐No
Do you use tobacco of any type? ☐Yes ☐No ☐ Former tobacco user ☐Never used tobacco	
If Yes, how often do you use tobacco? How much?	
Are you interested in quitting? ☐Yes ☐No	
Please rate your healthy eating habits, where 0 means your habits are unhealthy and 10 means your habits are very healthy.	

☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10

What are you typical eating habits, check all that apply ☐ Skip Breakfast ☐ 2 meals a day ☐ 3 meals a day ☐ Snacking between meals	
On average how many hours do you sleep at night?	
What is your preferred sleeping position	
On a regular basis how much do you exercise?	
What type of exercise do you do?	
What is the most significant thing you could do to improve your health?	
What is something that makes you happy?	

Patient Signature: _____ **Date:** _____