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 Family! **Your child's health history is important to us. Please fill out this form COMPLETELY.**		
Today's Date:		
Patient First Name:	Patient Last Name:	
Parent/Guardian Name (s):		
Relationship to Patient:		
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:		
Date of Birth: / /	Age:	Sex: ☐Female ☐Male ☐Other_____
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
☐ Please do not share results of this visit with this provider		
Who may we thank for referring you?		

What school/daycare does the patient attend:		
If you know your child's approximate height and weight please specify here	Height: _____'_____"	Weight: _____lbs

Why are you seeking care? ☐ **Pain** ☐ **Wellness** ☐ **Nutrition/Lifestyle** ☐ **Other**	
What is the area of complaint/concern?	
When did the symptoms start?	
Has your child experienced this before?	
Is this condition due to an automobile accident?	☐ No ☐ Yes

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Has your child been seen by another provider or received treatment for this condition?	☐ No ☐ Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done?
Has your child been checked by a doctor of chiropractic before?	☐ No ☐Yes Whom?

Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐Heart Defect	☐Reflux/GERD	☐Diabetic ☐Type I ☐Type II	☐Psoriasis
☐Excessive Bruising	☐Colic	☐Swollen glands	☐Eczema
☐Palpitations	☐Constipation	☐Other	☐Acne
☐Asthma	☐Diarrhea	**Developmental**	☐Rash
☐Persistent cough	☐Food Sensitivities	☐Delayed Speech	☐Birth marks
☐Mouth-breather	☐Poor Appetite	☐Delayed gross motor skills	☐Other
	☐Tongue/Lip Tie		
☐Congestion	☐Other	☐Delayed fine motor skills	
☐Bronchitis/ Pneumonia		☐ Delayed social skills	
☐Other		☐ Other	
Immune	**Constitutional**	**Musculoskeletal**	**Neurological**
☐Chronic colds	☐Lethargic	☐Joint/Bone pain	☐Dizziness
☐Laryngitis/Tonsillitis	☐Difficulty sleeping/ Irregular sleep patterns	☐Growing pains	☐Balance/ Coordination Issues
☐Ear & Sinus Infections			
☐Low Energy	☐Bed-wetting	☐Headaches	☐Epilepsy/Seizures
☐ UTI's	☐Pre-mature birth	☐Developmental /Motor Skill Delays	☐ Visual/hearing issues
☐Other			
	☐PTSD	☐Torticollis	☐ADD/ADHD
	☐Other	☐Scoliosis	☐Focus/Memory Issues
		☐Abnormal Walking	☐Speech Issues
		☐Poor Posture	☐Anxiety/Depression

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Prenatal History		
Place of birth:	Provider:	
Type of birth: ☐Vaginal ☐C-section ☐Water birth		Weeks gestation:
Was your child conceived naturally or with assisted reproductive technology?	☐Natural ☐Assisted	
Is your child adopted?	☐No ☐Yes	
Did baby's mother smoke?	☐No ☐Yes	
Did baby's mother consume alcohol?	☐No ☐Yes	
Was baby's mother taking any medications?	☐No ☐Yes, she took _____	
Were there any complications during pregnancy or birth?	☐No ☐ Yes	
Was labor induced?	☐No ☐Yes	
Were pain medications used during labor?	☐No ☐Yes	
Was your child malpositioned during birth? Breech, etc. ☐No ☐Yes		
Were there any interventions?	☐Doctor/Midwife assisted ☐Twisting/pulling ☐Forceps ☐Vacuum Extraction	
Did/do you breast feed your child?	☐No ☐Yes If yes, for how long?_____	
Did/does your child prefer one breast over the other?	☐No ☐Yes- ☐Right ☐Left	

Medications/Allergies		
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.		
Please list any known allergies your child may have. ☐ If no known allergies, check here		
1.	2.	
3.	4.	

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Daily Habits	
How much exercise does your child get?	
Does your child use a Johnny jump up, bumbo or any other sit/stand-assist?	
How much time does your child spend watching TV or a screen?	About_____ hrs. per day
What sports or activities does your child participate in?	☐My child doesn't engage in sports/activities ☐Yes, my child plays…
What position does your child sleep in?	☐Back ☐Side ☐Stomach
How much sleep are they getting a day?	_____ hrs.
What is a typical breakfast for your child?	
How would you rate their diet?	☐Poor ☐Fair ☐Healthy ☐Very Healthy

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

Please date/list reasons for any hospitalizations or surgical procedures.	
Date	**Reason**
Please describe any other injuries/accidents not mentioned previously.	
Date	**Injury**

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Are there any past or current medical conditions you have not told us about?
Is there anything additional we should know about your child?

Parent/Guardian Signature:_____ Date: _____

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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.

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Signature of Parent/Guardian: _____ Date: _____