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

29 RIVERSIDE STREET
UNITS A & B
NASHUA, NH 03062

MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIONIZE 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. ☐Other: ____________		
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 e-mail list? ☐ Yes, please! ☐No, thank you.		
Date of Birth: / /	Age:	Sex: ☐ Male ☐ Female ☐Other____________
Marital Status: ☐Single ☐Married	Spouse's Name:	
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		

What is your approximate…	Height: _____'_____"	Weight: ________lbs.
Are you/Is it possible you're pregnant? ☐ Yes ☐No ☐N/A	Est. Date of Delivery:	
Are you or your spouse trying to become pregnant? ☐Yes ☐ No	# of Children:	

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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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.		
Please list any known allergies you may have and what your reaction is to each. ☐ 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 (ex., diabetes, hypertension, cardiac, stroke, cancer, rheumatoid arthritis, etc.)	
Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Other:__________________	

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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 smoke, dip, vape, or use other tobacco products of any type? ☐Never user ☐ Yes ☐Former user If yes or former, explain:__________________________________	
If Yes, how often do you use? How much?	
Are you interested in quitting? ☐Yes ☐No	
Please rate your healthy eating habits: Unhealthy Somewhat healthy 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:** ____________________

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Patient Health Information Consent

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, BZH 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.

❐ Check here if you do not want information about your care shared with between Blue Zone Health providers.

In the event that the provider reasonably believes that the client is in danger, physically or emotionally, to themselves or another person, consent is given for the provider to warn the person in danger and contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. You acknowledge that you have been advised by the provider of the potential of the re-disclosure of your protected health information by authorizing recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the provider was conditioned on you providing this authorization.

Patient Name: ____ Date of Birth: ____________

Patient Signature:____ Today’s Date: ___________