Center for Preventive Medicine
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www.PreventiveMedicineNH.com

Welcome to our office. We are happy that you have chosen to come to us for your complementary healthcare. Our Office policies are designed to assure that we are able to provide the quality of care you expect from us, and that all of our patients are able to receive their care promptly and with minimal waiting times. This letter explains our office policies. Please take a few minutes to read it, sign it and return it to our staff with your patient information forms. We look forward to meeting you.

The undersigned acknowledges that he/she has requested healthcare services from the Center for Preventive Medicine. Many of the therapies offered at the Center are considered unconventional by mainstream medical establishment. Although some treatments have been in continuous use for a long period of time, they have been deemed "unproven" by such organizations as the American Medical Association, the Food and Drug Administration and certain insurance companies. Any therapy suggested to you can, of course, be refused and/or terminated at any time to receive only conventional therapies without the use of alternative or complementary modalities. Under no circumstance are you obligated to accept any treatment offered to you.

Disclosure of Information
All information provided to the Center for Preventive Medicine staff and clinicians is strictly confidential except for the following circumstances:

- Your insurance company requests information about your treatment in order to process a claim or certify
- care.
- The patient authorizes the release of information by signing a release form naming the specific person to receive the information.
- Certain circumstances where we are required by law to release information (e.g., court subpoena, suspected abuse, etc.)

Financial Terms
You are expected to pay for your care in full at the time services are rendered. We will provide you with a universal health insurance claim form so that you may submit a claim to your insurance company for reimbursement. We do not participate with any insurance companies, and do not submit insurance claims. If an amount owed by a patient is not received on a timely basis, the patient may be responsible for reasonable attorney fees and the cost of collection. There is a $15 charge for copying medical records, and there is a $25 fee for returned checks.

Canceled/Missed Appointments and Late Arrivals
When you make an appointment, we are reserving time on a practitioner's schedule that is no longer available to other patients. We do require a $100 deposit for all new patient appointments; which will be applied to the first visit. If you cannot make an appointment, we ask that you cancel your appointment at least 24 hours in advance. A new patient deposit will be refunded if you give 24 hours advance notice of cancellation. The Center's voice mail message center 603-673-7910 accepts messages about appointment cancellations at any time (24 hours/day). Missed appointments will result in a $50 charge.

Late arrivals can create scheduling problems with other patients. If you must be late, please call to let us know. If you arrive more than 15 minutes late, we may not be able to accommodate your appointment without interfering with the scheduled times of the other patients.

Acknowledgement and Agreement
I have read the above information and thoroughly acknowledge, understand, and agree to all of the above information, including the financial terms as stated above.

Patient (or Parent/Guardian) PRINTED Signature Date

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MEDICAL HEALTH AND HISTORY FORM

(Please Print)

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name:_____ First:_____ MI:____

Birth Date:_____ Age:_____

Street Address:_____ P.O.Box:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Mobile Phone:_____

E-mail Address:_____ Occupation:_____

Other family members seen here:_____

Pharmacy Name/Address:_____ Pharmacy Phone:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):_____

Relationship to patient: _____ Home Phone:_____ Mobile Phone: _____

PRIMARY COMPLAINT

Please list your major problems and /or symptoms and the approximate date it began (If none, please write your reason for this consultation). Please rank in order of importance to you.

1.	
2.	
3.	

ALLERGIES

Please list any known allergies; Drugs, Foods, Environmental, etc.

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CURRENT MEDICATIONS AND/OR SUPPLEMENTS

Please write the name, dosage and frequency of all current medications and Supplement. Try to bring the label of any multiple or combination formulas. Use a separate sheet if necessary.

Name:	Dosage:	Frequency:

Do you or have you used hormone replacement:

If yes, what?_____ When:_____ Dosage:_____

EXPECTATIONS

What are your expectations regarding what you would like our office to provide for you?

RESULTS OF OTHER EVALUATIONS

If you have seen other practitioners for these problems, indicate the results of these evaluations.

PRIMARY CARE PROVIDER

Do you have a primary care provider (PCP)? YES / NO

If yes, please complete the information below:

PCP Name/Address:_____

Office Phone Number:_____

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LIFESTYLE AND HABITS

Tobacco:

Do you currently smoke?	YES / NO	How long?
Do you currently chew tobacco?	YES / NO	How long?
Did you ever smoke?	YES / NO	When did you stop?

Alcohol (wine, beer, liquor):
How often do you drink? Never <1 time per week 2-5 times per week At least once daily

What do you drink:_____ Was drinking ever a problem? When?_____

Caffeine:

How many cups of the following do you drink?	Coffee	Black Tea	Green Tea	Cola	Diet Cola	Chocolate
	_____	_____	_____	_____	_____	_____

Recreational Drug Use:
Type/Frequency:_____

How often do you exercise? Never Rarely Sometimes Regularly Competitively

SLEEP HABITS

How do you sleep? Well Trouble falling asleep Trouble Staying Asleep Insomnia

How long has this been happening?_____

How many hours do you sleep per night on average?_____ Do night sweats wake you up? YES / NO

Do you dream? YES / NO If yes, how many times per week?_____ Do you wake up tied? YES / NO

Is your room completely dark when you sleep at night (no night light, street lamp, TV, etc.)? YES / NO

Do you get at least 30 minutes of outside daylight time several days each week? YES / NO

MEDICAL HISTORY

Please indicate if you or any family members, or grandparents, have ever had any of the following. Specify who, including **yourself.**

Alcoholism	Allergies	Anemia
Arthritis	Asthma	Bleeding/bruising
Cancer	Convulsions/epilepsy	Crohn's disease/colitis
Diabetes	Digestive disease	Drug Problems
Eczema/psoriasis	Frequent infections	Heart disease
Hepatitis	Herpes or shingles	High blood pressure
High cholesterol	Hypoglycemia	Lupus
Mental illness	Migraines	Pneumonia
Polio	Prostate problems	Rheumatic fever
Rheumatoid disease	Sinus disease	Strokes
Thyroid problems	Tuberculosis	Ulcers
Urinary infections	Venereal disease	Weight problems

Comments/explanations:

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FAMILY HISTORY

List family members, their ages, or if deceased, their age at death, and any medical problems they have now or ever had.

Mother _____ Father _____

Grandmother _____ Grandmother _____

Grandfather _____ Grandfather _____

Siblings _____

Children_____

DENTAL HEALTH

Mercury – Amalgam Fillings? YES /NO Removed by specialty dentist? YES / NO

Root Canal? YES / NO Gum Disease? YES / NO

YOUR TEST INFORMATION

Please specify when your tests were done if possible:

Current Height: _____ feet _____ inches Current Weight: _____ pounds

Last physical exam: _____ X-rays: _____

GI Series: _____ Gall bladder tests: _____

Kidney/bladder series: _____ EKG: _____

Angiogram/catheterization: _____ Ultrasound tests: _____

Blood tests: _____ Other tests: _____

HOSPITALIZATIONS AND SURGERIES

Date:	Type or Reason:

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SYMPTOM AND SYSTEM REVIEW

Write all the appropriate letters in the right-hand columns. Leave blank if the problem does not apply to you.
Write "C" for current problem; "I" if it is an intermittent problem; "P" for a past problem.

Headaches
Neck lumps or swelling
Loss of balance
Dizzy Spells
Vertigo
Blackout or fainting
Blurry vision
Double vision
Cataracts
Eye pain or itching
Watering eyes or redness
Hearing difficulties
Earaches or drainage
Noises or ringing in ears
Recurrent ear infections
Dental problems/decay
Sore or bleeding gums
Sore tongue
Coated Tongue
Loss of taste or smell
Sores in or around mouth
Difficulty swallowing
Cold sores or fever blisters
Sinus or nasal congestion
Runny nose
Frequent colds
Nasal polyps
Swollen glands
Recurrent fevers or chills
Hoarse voice
Shortness of breath
Wheezing or gasping
Aching muscles or joints
Chest colds or pneumonia
Back or neck pain

High blood pressure
Skipped heartbeat
Racing Heart
Chest pain or pressure
Swollen feet and ankles
Difficulty breathing at night
Varicose veins or phlebitis
Recurring indigestion
Nausea or vomiting
Intestinal gas/flatulence
Belching
Bloating
Abdominal pain or cramps
Constipation
Diarrhea or loose stools
Rectal itching
Blood with stools
Black stools
Pain in rectum
Jaundice
Hepatitis/pancreatitis
Colitis
Crohn's Disease
Diverticulitis/diverticulosis
Frequent urination
Brown and red urine
Decreased force or urine
Involuntary escape of urine
Difficulty starting urination
Kidney or bladder infection
Venereal disease
Osteoporosis
Coughing blood
Joint stiffness

Weakness
Painful feet
Leg cramps
Trembling or tremors
Seizures or epilepsy
Numbness or tingling
Skin tumors
Dry Skin
Acne
Eczema
Skin rashes
Psoriasis
Dandruff/seborrhea
Hives
Itching or burning skin
Easy bruising
Hypothyroid (low)
Hyperthyroid (high)
Weight gain
Weight loss
Feel excessively warm
Feel excessively cold
Loss of appetite
Constant hunger
Fatigue or weariness
Night sweats
Low blood sugar
Nervousness or anxiety
Depression
Suicidal thoughts
Sought psychological help
Coughing
Arthritis
Heart murmur