New Hampshire
REGENERATIVE CENTER

# WELCOME TO OUR OFFICE!

**Patient Full Name:** _____ **Nickname**_____

**Phone** _____ **Email**_____ **DOB** _____

**Address** _____ **City** _____ **State** _____**Zip**_____

**Emergency Contact:** _____ **E. Contact Phone** _____

**Occupation:** _____ **How did You hear About Us?** _____

**What is the reason (problem area/body part) that is bringing you in?** _____

**CURRENT**: Medications/Supplements *(if no medications please write "none"/if large list please supply copy)*

_____

**PAST MEDICAL HISTORY**:
*(Surgeries, Accidents, Injuries, Stroke, Heart Attack, Organ Donor, Blood Clots etc.)*

_____

_____

**ALLERGIES**:_____

**SULFA ALLERGY?** YES NO

**ARE YOU CURRENTLY TAKING ANTIBIOTICS?** YES NO

**HAVE YOU TAKEN ORAL STEROIDS IN THE LAST 4 WEEKS?** YES NO

**HAVE YOU RECEIVED CORTISONE INJECTIONS IN THE LAST 4 WEEKS?** YES NO

**ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT?** YES NO

**DO YOU HAVE A HISTORY OF BLOOD CLOTS?** YES NO

**DO YOU HAVE A HISTORY WITH CANCER?** YES NO
*(If yes, please list history below. Include **Type, Treatments, Years, Years remission**)*

_____

_____

**DO YOU HAVE A HISTORY OF THE FOLLOWING***? (Please Circle All That Apply)*

| | | | |
|---|---|---|---|
| VASOVAGAL SYNCOPE | SEIZURES | HEADACHES | STROKE |
| DIABETES | NECK PAIN | BACK PAIN | WHIPLASH |
| ARTHRITIS | KNEE PAIN | SPRAINS | SHOULDER PAIN |
| HIP PAIN | HYPERTENSION | HYPOTENSION | HAND/WRIST PAIN |
| FOOT/ANKLE PAIN | BROKEN BONES | | |

NUMBING/TINGLING ANYWHERE IN THE BODY? IF YES, WHERE? _____

**WHICH OF THE PREVIOS SECTION WOULD YOU CONSIDER THE 'WORST'?**

_____

**HOW LONG HAVE YOU BEEN SUFFERING WITH THIS ISSUE?**

_____

**WHAT ACTIVITES WOULD YOU LIKE TO DO IF THIS WAS NO LONGER A PROBLEM?**

_____

**ADDITIONAL COMMENTS/CONCERNS:**

_____

_____

_____

**HAVE YOU ATTEMPTED ANY OF THE FOLLOWING SERVICES FOR RELIEF?**
*(Please circle on a scale of 1-10 how much specific service helped)*

- **PAIN MEDICATIONS** 0 1 2 3 4 5 6 7 8 9 10
- **PHYSICAL THERAPY** 0 1 2 3 4 5 6 7 8 9 10
- **CHIROPRACTIC CARE** 0 1 2 3 4 5 6 7 8 9 10
- **CORTISONE INJECTIONS** 0 1 2 3 4 5 6 7 8 9 10

**PLEASE INDICATURE YOUR PERSONAL USE OF THE FOLLOWING:**

| | NEVER | OCCASIONALLY | OFTEN |
|---|---|---|---|
| **ALCOHOL** | | | |
| **TOBACCO** | | | |
| **WATER** | | | |
| **EXCERCISE** | | | |

We are pleased to have the following professional, experienced & licensed providers on staff that specialize in treating a wide variety of conditions, both chronic and acute in nature:

**LISA PEPPE** MSN, APRN, FNP-BC
**DR. THOMAS PRATT** D.C.
**TAYLOR DOXSEE** LMT, CPT

# OFFICE POLICIES

NEW HAMPSHIRE REGEN CENTER has adopted the following policies. Through understanding of these policies is necessary to effectively serve all of our valued patients.

1. **Payment is expected at time of service**. We do not accept insurance at this clinic therefore we do not directly bill your insurance company, however if requested we will provide you with the necessary information for you to submit to your insurance company on your own behalf.
2. **If you are late for an appointment, you will receive only the remainder of the time left** in your time slot and you will be responsible for the full session price.
3. **Missed appointments without a 24-hour notice of cancellation will incur a fee equal to 60%** of the missed appointment.

# NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. New Hampshire Regenerative Center uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes and to evaluate the quality of care that you receive. New Hampshire Regenerative Center will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. New Hampshire Regenerative Center may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

New Hampshire Regenerative Center must maintain the privacy of the protected health information, provide you with a notice of its legal duties and privacy practices with respect to your health information, abide by the terms and of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with the health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.
If you have any questions or complaints, please refer to Kayla Leo (Practice Manager)

I hereby authorize the Healthcare Provider(s) to provide any and all forms of treatment, evaluation, imaging , and therapy that may be indicated in connection with the care of the patient above. I further authorize and consent that the Healthcare Provider chooses and employs such assistance as (s)he sees fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the Healthcare Provider. I agree to pay for all services personally rendered in this office.

_____ _____

**Patient Signature** **Todays Date**