



CHECK-IN

Please check in no later than 24 hours before your appointment. Your visit may be cancelled or rescheduled if Check-In is not received.
You may return this Check-In via secure patient portal or call us at 603-718-8328 with your answers. Voicemail is available 24 hours/day and 7 days/week.

1. What would you like your provider to address during your visit? Please be specific and provide details: _____

 2. Any other symptoms or concerns in the last week? If yes, please describe severity, frequency, and other details: _____

 3. Any recent life changes or events that may be affecting your health? If yes, please describe: _____

 4. Any new diagnoses, testing, or lab work since your last visit? If yes, please describe, provide date, and results if available: _____

 5. Any new supplements, topical preparations, or prescriptions since your last visit? If yes, please list and provide date started: _____

 6. Any new sensitivity or allergy to foods, environment, or drugs since your last visit? If yes, please list: _____
 7. Do you need refills on anything prescribed from this office? If yes, please list: _____
 8. Do you need access to our online dispensary for prescriptions, recommendations, or refills? _____
 9. Have you received a COVID-19 vaccination? If yes: on what date and which dose (1st, 2nd, or single dose) was received?
Enter "on file" if you have previously provided this information. _____
 10. If you answer "yes" to any question below, please provide details. *If "no" applies to all questions below, please answer "no" or "no to all". Do not answer "N/A".* _____

- a) Within the past 24 hours have you had a fever of 100°F (38°C) or above? If yes, please provide temperature reading(s).
 - b) Within the past 14 days, do you or have you had any flu-like symptoms including but not limited to: sore throat, new loss of taste or smell, cough, runny nose, sneezing, fever or feeling feverish, chills, shaking with chills, shortness of breath, difficulty breathing, headache, new body aches or muscle pain, skin changes or rash, nausea, vomiting, gastrointestinal upset, abdominal pain, diarrhea, stroke, blood clot, delirium or confusion? If yes, provide details.
 - c) Within the past 14 days have you been exposed to any person (including children) with any of those symptoms? If yes, provide details.
(Healthcare workers caring for patients while wearing appropriate PPE should answer no to this question).
 - d) Within the past 14 days, did you travel to or from any area within or outside of the USA that is currently experiencing any type of infectious disease outbreak? If yes, provide details.
 - e) Within the past 14 days, have you been in close contact with any person (including children) who has recently traveled to or from any area within or outside of the USA that is currently experiencing any type of infectious disease outbreak? If yes, provide details.

We are committed to your health and safety. The preventive methods ([NH Universal Best Practices](#)) utilized to mitigate risk of COVID-19 and other transmissible diseases are standard procedure at AIMA of Nashua PLLC. This includes pre-visit health screening, face mask use, good and frequent hand hygiene, decreasing overall time in-office and limiting discussion during in-office visits, telehealth services, social distancing and reducing physical contact, cleaning and disinfection of frequently touched surfaces, limiting shared objects, improving ventilation, and quarantine or isolation when deemed necessary. Thank you for your compliance, and for doing your part in protecting yourself, your community, and your health care providers.

PRINT NAME OF PATIENT: _____
RELATIONSHIP TO PATIENT (self, guardian, etc.): _____
PRINT NAME OF GUARDIAN (if applicable): _____
DATE TODAY: _____
DAY, DATE, AND TIME OF YOUR APPOINTMENT: _____
SIGNATURE: _____