Patient Introduction

First Name _____MI___Last Name _____Nickname_____Date_____

Address _____ City _____ State _____ Zip _____

Cell Phone(_____)_____ Home Phone (_____)_____Work Phone (_____)_____

Cell phone carrier for texting appointment confirmations/updates _____

E-mail Address_____ Occupation _____ Employer _____

Seasonal/Other Address _____ City _____State _____ Zip_____

Gender: ☐F ☐M Marital Status: ☐S ☐M ☐W ☐D ☐LS Birthday ____/____/____ Age _____

Name of Spouse_____ Number of Children_____ Ages of children _____

Language_____ Race _____ Ethnicity_____

How did you hear about our office?_____

Emergency Contact Name _____ Phone (_____)_____ Relationship_____

Name of person responsible for account _____ Method of payment_____

Current Health Status/History

Briefly describe your primary health concerns/symptoms (provide details on pg.2) _____

_____

_____

Other doctors seen for this condition	Treatment rendered	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other physicians seen within the last year:	For what condition(s):
_____	_____
_____	_____
_____	_____

Primary Care Physician _____City and State _____

Current medications (prescription & non-prescr) w/dosage & how long have been using _____

_____

How many times and when have you been given antibiotics? _____

Current nutritional supplements _____

_____

Past surgeries, with dates_____

_____

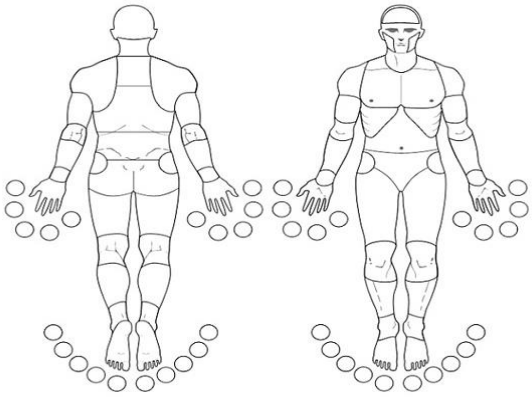
Allergies, including drug allergies_____

Major Symptoms/Concerns

Name_____ **Date**_____

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Shade in below where you have pain or other symptoms.



When and how did this condition develop?_____

Any accidents, falls, etc. that might have caused your condition? □Yes □No If yes, describe accident and give location _____

_____

Have you previously experienced these symptoms? □Yes □No If yes, explain?_____

What activities, movements, or positions (ie. work, sitting) increase your symptoms?_____

What relieves your symptoms (ie. laying down, walking, exercise)_____

Is your pain sharp, stabbing, burning, dull ache, numbness, or tingling?_____

Does the pain radiate to any other body area (ie. arms or legs)?_____

What time of day (or night) are your symptoms the worst?_____

Is this condition affecting your home life_____occupation_____sports/exercise/recreation_____rest and sleep_____

Rate your overall pain or symptoms: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

Any Chiropractic Physician consulted in the past? □Yes □No Name of Physician_____

Date consulted_____ For what condition_____Response to treatment_____

List any prior auto accidents: Date(s):_____Nature of injuries:_____Type of treatment_____

Detailed Symptoms

Rate current symptoms with #1-10 for Intensity Level (mild to severe). **Leave a line blank if no symptoms.**

__R__L Neck pain- (rate 1-10)
__R__L Shoulder -
__R__L Arm-
__R__L Elbow -
__R__L Wrist -
__R__L Hand -
__R__L Upper Back -
__R__L Lower Back -
__R__L Hip -
__R__L Buttocks -
__R__L Thigh -
__R__L Knee -
__R__L Leg -
__R__L Ankle -
__R__L Foot -
__R__L Headaches -
__R__L Jaw Pain/Clicking-
____ Fatigue-
____ Insomnia -
____ Dizziness-
____ Fainting-
____ Equilibrium/Balance issues-
____ Loss of Memory -
____ Lack of Concentration-
____ Tremors-

____ Eyes Sensitive to Light- (rate 1-10)
____ Ears Ringing -
____ Loss of Taste/Smell -
____ Sinus Problems-
____Watery or itchy eyes
____ Chest Pain -
____ Heart Palpitations -
____ Shortness of Breath -
____ Nervousness/Anxiety -
____ Depression -
____ Irritability-
____ PMS Symptoms-
____ Genital burning, itching or discharge-
____ Eczema-
____ Psoriasis-
____ Nail Fungus-
____ Canker Sores-
____ Indigestion -
____ Nausea -
____ Vomiting -
____ Diarrhea -
____ Constipation-
____ Bloody stools-
____ Rectal itching-
Other_____

Social History & Health Habits

Name_____ **Date**_____

Height_____ Weight _____ Change in last year_____ Your desired weight_____ Rate your stress level on a scale of 1-10 _____

Typical Daily Diet:
Breakfast_____ Snack _____

Lunch_____Snack _____

Dinner _____Snack _____

How many times per week do you eat out? _____

Approximate number of times you urinate during the day?_____ Night?_____ How often do you have a bowel movement?_____

How many cups/glasses per day do you drink of: water____ juice___ coffee___ tea/iced tea___ sports drinks___ soda___ alcohol ___

If you smoke, how many per day? _____ Since when?_____ Has your vision changed lately? ☐Yes ☐No

Do you sleep well? _____ # of hours/night_____ Do you sleep on your: ☐back ☐side or ☐stomach

What time do you go to sleep each night? _____ What time do you get up in morning?_____ Number of times wake up at night?_____

List type and frequency of exercise/sports_____

Women Only: Menstrual History

Date of onset of last period____/____/____ Are your periods regular? ☐Yes ☐No Are you currently pregnant? ☐Yes ☐No

If you have PMS or menopausal symptoms, please describe_____

Have you used birth control pills, or contraceptive patch, implant, injection or IUD; when and for how long? _____

Family Health History

	SELF	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTER(S)		CHILDREN	
	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )	AGE ( )
Arthritis										
Asthma										
Anxiety										
Autoimmune Condition										
Back Pain										
Breast Cysts										
Cancer (list type)										
Celiac Disease										
Dementia/Alzheimer's										
Depression										
Diabetes										
Digestive Problems										
Headache/Migraine										
Heart Condition										
High Blood Pressure										
Kidney/Bladder Cond.										
Lung Condition										
Parasites										
Prostate Condition										
Seizures										
Sinus Problems										
Skin Condition										
Thyroid Condition										
Uterus/Ovaries Disorder										

Name_____ **Date**_____

Consent for Treatment

I hereby authorize Thomas Rofrano, DC and whomever he may designate as his associate(s) or assistant(s) to perform an evaluation, diagnostic tests and to administer treatment as they deem necessary. I understand that no guarantee has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me, and that this office can prepare any necessary forms to assist me in processing my insurance claims. Any amount authorized to be paid directly to this office will be credited to my account upon receipt, and I permit this office to endorse remittances for credit to my account. However, I clearly understand and agree that all services rendered are charged directly to me, and I am personally responsible for payment. Accounts over 30 days past due are responsible for cost of collection and an interest rate of 1.5%/month from the date payment was initially due.

Patient's Signature_____Date_____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have, will or decline the opportunity to read them, and understand the Notice of Privacy Practices. I understand that this form scanned in my file and maintained for 6 years.

Patient's Signature_____ Date_____/_____/_____

Parent, Guardian or Patient's Legal Representative's Signature_____ Date_____/_____/_____

Authorization of Benefit Payments to Provider & for Designated Representative to Appeal a Determination

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

I hereby authorize my Insurance Company/Insurance Administrator to pay by EFT or check, and sent directly to: Natural Medicine Clinic, 2401 PGA Blvd, Suite 132, Palm Beach Gardens, FL 33410, the benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I give this office power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

I authorize Natural Medicine Clinic to appeal my insurance company's determination on my behalf, as my Designated Representative. As part of the appeal, I authorize my insurance company in its decision letter and in connection with processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal. I understand that these communications may contain all medical and financial information contained in my insurance file, including all conditions and treatment in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law.

Patient's Signature_____ Date_____/_____/_____

Attorney Representative and Protection of Balance

I irrevocably direct my attorney to pay any outstanding bills out of my settlement and, in effect, protect any such balances. I fully understand that I am directly responsible for all medical bills, and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature_____ Date_____/_____/_____

Consent for Treatment of a Minor

I hereby authorize Thomas Rofrano, DC and whomever he may designate as his associate(s) or assistant(s) to perform an evaluation, diagnostic tests and to administer treatment as they deem necessary to my child (name) _____.

Parent or Guardian's Signature_____ Date_____/_____/_____

Imaging / Medical Records Release

I request the release of medical records of (patient's name) _____DOB_____
from: _____
I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below, my complete medical records, including copies of x-ray images MRI scans.

Please forward to: Natural Medicine Clinic 2401 PGA Blvd, Suite 132 Palm Beach Gardens, FL 33410
Fax: 561-627-5895 Email: info@nmcwellness.com Phone: 561-627-5800

Patient's Signature_____ Date_____/_____/_____