



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 _____

Social History & Health Habits

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? _____ How often do you eat gluten- wheat, barley, rye, oats? _____

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										

Consent for Treatment and Acknowledgement of Receipt of Notice of Privacy Practices

I hereby authorize Thomas Rofrano, DC and whomever he may designate as his associate or assistant 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 either submit claims or provide me a statement to assist me in processing any possible 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 at time of service. 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.

I was provided a copy of or a link <http://nmcwellness.com/wp-content/uploads/2013/09/Notice-of-Privacy-Practices9-13.pdf> to the Notice of Privacy Practices and that I have, will or decline the opportunity to read it and understand the Notice of Privacy Practices. I acknowledge that this form is to be 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 _____/_____/_____

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 and 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 _____/_____/_____

Health Assessment Form

Name: _____ Date: _____

Please list your 5 major health goals, things you want to improve, in order of importance:

1. _____ 4. _____
 2. _____ 5. _____
 3. _____

Please circle the appropriate number on all questions below. 0 for the least/never to 3 for the most/always.

Category I- Cn _____	
Feeling that bowels do not completely empty	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II- IntPm _____	
Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III- Chem Tol _____	
Intolerance to smells	0 1 2 3
Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV- St L _____	
Excessive belching, burping or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting proteins and meats, undigested food in stool	0 1 2 3

Category V- St H _____	
Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0 1 2 3

Category VI- SI/Pncr _____	
Difficulty eating roughage and fiber	0 1 2 3
Indigestion and fullness lasting 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/ or vomiting	0 1 2 3
Stool undigested, foul smelling, mucus like, greasy or poorly formed	0 1 2 3
Frequent loss of appetite	0 1 2 3

Category VII- SI _____	
Abdominal distension after consumption of fiber, starches and sugar	0 1 2 3
Abdominal distension after certain probiotic or natural supplements	0 1 2 3
Decreased gastrointestinal motility, constipation	0 1 2 3
Increased gastrointestinal motility, diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Suspicion of nutritional malabsorption	0 1 2 3
Frequent use of antacid medication	0 1 2 3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis / Diverticulitis, or Leaky Gut Syndrome?	Yes No

Category VIII- Lv GB _____	
Greasy or high fat foods cause distress	0 1 2 3
Lower bowel gas and / or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burp fishy taste after consuming fish oils	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin especially palms	0 1 2 3
Dry, Flaky skin and or hair	0 1 2 3
History of gallbladder attacks or stones	Yes No
Have you had your gallbladder removed?	Yes No

Category IX- Lv Dtx _____	
Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul smelling stool	0 1 2 3

Category X- Hglyc _____	
Craves sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going / get started	0 1 2 3
Get light headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful between meals	0 1 2 3
Blurred vision	0 1 2 3

Category XI- InsRs _____	
Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal to or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Health Assessment Form (2)

Category XII- LAdr ____

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII- HAdr ____

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Have more energy at night than the entire day	0	1	2	3
Anxiety	0	1	2	3

Category XIV- El ph Bal ____

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV- LTh ____

Tired/sluggish	0	1	2	3
Feel cold- hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI- HTh ____

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII- P ____

(Males Only)				
Urination difficulty or dribbling	0	1	2	3
Frequent Urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII- An ____

(Males Only)				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexpected weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX ____

(Menstruating Females Only)				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss / thinning	0	1	2	3

Category XX ____

(Menopausal Females Only)				
How many years have you been menopausal?	_____years			
Since menopause, do you ever have any uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

Any other symptoms that you have not listed or anything else you would like us to know?