Patient Introduction

First Name____________________MI___Last Name________________________Nickname___________________Date_______

Address____City_________________________State_______Zip____________

Cell Phone (____)_________________________Home/other Phone (____) ______________________

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___________________________________

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 taken antibiotics? ____

Current nutritional supplements ____

____

Past surgeries, with dates____

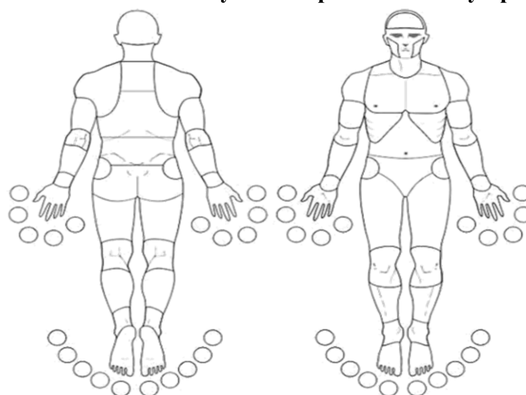
____

Allergies, including drug allergies

Name: ______________________________ Date: ____________________

Major Symptoms/Concerns

Shade in below where you have pain or other symptoms.



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

When and how did these conditions develop?____
____
____

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 (No pain) 1 2 3 4 5 (Moderate) 6 7 8 9 10 (Severe)

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-	Fatigue-	Depression –
R	L	Shoulder -	Insomnia -	Irritability-
R	L	Arm-	Dizziness-	PMS Symptoms-
R	L	Elbow -	Fainting-	Genital burning, itching or discharge-
R	L	Wrist -	Equilibrium/Balance issues-	Eczema-
R	L	Hand -	Loss of Memory-	Psoriasis-
R	L	Upper Back -	Lack of Concentration-	Nail Fungus-
R	L	Lower Back -	Tremors-	Canker Sores-
R	L	Hip -	Eyes Sensitive to Light-	Indigestion –
R	L	Buttocks -	Ears Ringing –	Nausea –
R	L	Thigh -	Loss of Taste/Smell –	Vomiting –
R	L	Knee -	Sinus Problems-	Diarrhea –
R	L	Leg -	Watery or itchy eyes-	Constipation-
R	L	Ankle -	Chest Pain –	Bloody stools-
R	L	Foot -	Heart Palpitations –	Rectal itching-
R	L	Headaches -	Shortness of Breath –	Other-
R	L	Jaw Pain/Clicking-	Nervousness/Anxiety –	

Name: ________________________________Date:____________________

Social History & Health Habits

Height_______Weight______Change in last year_______Your desired weight_______

Rate your stress level on a scale of 1-10 for Home____ Work___ Relationships/family___

How much support do you have at home for your health improvement?________

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?________

Cups/glasses per day you drink of: water___ juice____ coffee____ tea/iced tea____sports drinks____ soda____alcohol___ kombucha___

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 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 provide treatment as they deem necessary. I understand that no guarantee has been made to the results that may be obtained. and this does not replace the care of my medical providers. I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me, and that this office can 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 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_____/______/______

Name: ________________________________ Date: ____________________

Health Assessment Form

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

Catergory 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, meats, and undigested fool 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, IBS, 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 lightheaded 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

Name: ______________________________ Date: ____________________

Health Assessment Form (2)

Category XII- LAdr ____

Symptom				
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 ____

Symptom				
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 _______

Symptom				
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 ____

Symptom				
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 ____

Symptom				
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)

Symptom				
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)

Symptom				
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)

Symptom				
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)

Symptom				
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?