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_____

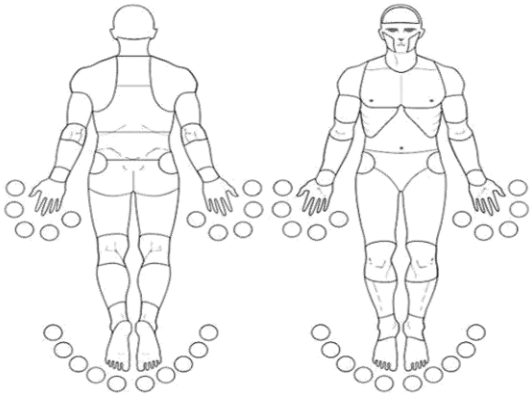
_____

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 1 2 3 4 5 6 7 8 9 10
No pain Moderate 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___ Other_____

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

Have you been exposed to a moldy environment? ___N __Y If so, provide details_____

Have you been exposed to chemicals? ___N __Y If so, provide details_____

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 authorize Thomas Rofrano, DC and his associate or assistants to perform an evaluation, diagnostic tests, and to provide treatment as they deem necessary. I understand that there is no guarantee to the results that may be obtained, and response to care depends on many factors, including compliance to the specific recommendations of my treatment plan.

I understand that the care I receive is focused on determining my root causes and providing me with solutions from a nutritional, physical, and wellness perspective so I can enhance my ability to heal and enjoy vibrant health. This holistic approach is different from traditional medical care which focuses on treating symptoms or conditions with prescription drugs and surgery, so I understand my care here does not replace the care of my medical doctors.

For follow up appointments, I understand there is a 48-hour change or cancelation notice required or the full fee is charged since this time is reserved solely for me.

I understand that this office does not accept insurance but can provide me a statement for me to submit for any possible coverage, although there is no assurance that any of the visits or labs will be covered. 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. I 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 the opportunity to read and understand it. 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_____/_____/_____

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_____/_____/_____

2nd Parent Signature (if separated or divorced) _____ 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	0 1 2 3
Abdominal 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 protein/meat, or 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, 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
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 ___

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?