Office Use only:
Scanned:____ BD list:____ Pt Ct list:____
A list:___ PstC list:___ E list:___ Cnt____

Dr. Robert Manfredini, D.N.
Naprapathy &Wellness

Confidential Health History Summary – Please Print

Name____ Date ______________

Address__________________________ City________________ State____________ Zip_________

Phone (H)________________________ (W)________________________ (C)________________________

Email____

Can I put you on my wellness email distribution list? Yes No

Age__________ Birth-date___________________

Nearest Relative_____________________________________ Phone___________________

Occupation__________________ (full/part time?) Employer______________________________________

Address__________________________ City________________ State___________ Zip_________

Insurance Co.______________________________ Policy #________________ Group # _____________

Address_______________________________ City______________________ State______ Zip________

Spouse's Policy? Yes No Name and Birth Date:____

How did you hear about me?____

If it was a referral, who? _____________________________ Phone (H) ______________________

Last health practitioner seen?____________________________________ When?____________________

Address_______________________________ City_________________ State_______ Zip_________

Phone (H) ________________________ (F) ____________________

Blood Type ___________

When was your last blood test?__________________________ Findings: ___________________________

Your Current Health Problems

1. What is your main reason for coming in today? ____
____

2. Did this happen at work? Y N Car Accident? Y N

3. What day did this happen? _______________

4. If you have a specific health condition please describe in detail: _________________________________
____
____

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5. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation?__________________________________
____
____

List in order of importance other health problems that are troubling you:
1) ____ & length of time_______________
2) ____ & length of time_______________
3) ____ & length of time_______________
4) ____ & length of time_______________

Other problems:____

How long has your <u>main</u> problem been bothering you?____________________________________

Is your "<u>main problem</u>" getting *[better, worse, same]* and for how many days or weeks?________________

What kind of treatment have you received and from whom?____
____
____
____

Have you ever seen a naprapath, naturopath, osteopath, chiropractor, acupuncturist or other alternative health practitioner for your current problem? Y N , or for any problem Y N.

What was the therapy and what were the results?____

<u>Medications</u>:

Name	Dose	Times per Day	How Long

Your Health History

The general state of your health is: ( ) excellent ( ) good ( ) average ( ) fair ( ) poor

On the average describe your energy level from 1 (lowest) to 10 (highest):_______________

When during the day is your energy the best?_____________ worst? _____________

Your current approximate weight?_________ height?_________ Weight one year ago________

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Have you experienced any traumas within the last five-years?

Automobile Accident: Y N Is so, when:________________________ Outcome:____________________

Slip & Fall Accident: Y N Is so, when:________________________ Outcome:____________________

Cancer Treatment: Y N Is so, when:________________________ Outcome:____________________

Athletic Injury: Y N Is so, when:________________________ Outcome:____________________

Agreement and Signature:

I understand that I am responsible for payment in full to Dr. Robert J. Manfredini, D.N. for all services rendered whether it be insurance assignment or point-of-service care. Also, I do hereby waive, release and forever discharge Dr. Robert J. Manfredini, D.N. and its officers, agents, employees, representatives, executors, and all others from any and all responsibility or liability for injuries or damages resulting from the care I receive from Dr. Robert J. Manfredini, D.N.

____ ________________

Signature of Patient Date

Patient Acknowledgement for use and/or disclosure of Protected Health Information (PHI) To Carry our Treatment, Payment, and Healthcare Operations.

I, ____, hereby state that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided, upon request, in a folder at the front desk, and will be on a future website. I may also request a copy from the front desk at any time via U.S. Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____

Name of Patient Signature Date

____

Signature of Guardian Date Relationship

____

Witness' Signature/Printed Name Date *Revised January 2012*