Dr. Robert Manfredini, D.N.

Naprapathy &Wellness

Health History Form

Thank you for choosing my services for your pain management, lymphatic disorder, or nutritional issue. My approach to providing relief for your issue is simple in its orientation but very specific in the application. I use the most comfortable, least aggressive technique for the greatest positive effect. In other words, I use gentle techniques to get you pain-free.

I identify the muscular imbalance and its associated pattern to undo the chain of imbalance so you can experience long-term pain relief. Instead of just focusing on the problem area I take a look at the whole body to find the whole problem. That is why most patients experience relief in one visit. However, it is important to understand that relief may be achieved within one visit; but the "chain-of-imbalance" may take a few visits to remove and restore balance.

What really happens is an improvement of nervous and lymphatic systems communication with the brain. Improved function leads to better health and pain-free daily living.

Besides performing a Naprapathic evaluation or Vodder-based Lymphatic Massage I also utilize nutrition as a means for improvement of health status. Naprapaths are the only licensed healthcare providers who have a formal curriculum in nutrition. Everybody understands that the foods you eat directly influence your health and healing process; I can help you determine which foods may benefit you the most. Lastly, I will give you appropriate exercise recommendations or instructions as I have a formal background in exercise physiology and kinesiology and have been designing fitness and health programs for athletes and non-athletes for over 19 years.

For your consideration…

I feel that knowing and understanding your blood chemistry is very important to gauging your health. A positive outward appearance is usually a good indicator of general health but sometimes a problem lies deeper and blood chemistry may show it before it mars the positive exterior image.

I recommend you have your personal physician perform a blood chemistry panel or other appropriate tests on a biennial basis or for any chronic or acute symptoms. I also recommend an online service called HealthcheckUSA which is an on-line service that schedules blood-work-ups at relatively convenient, local laboratories. You simply visit the website: www.healthcheckusa.com and choose the tests you want. Place a credit card order and they will send you a confirmation receipt which you take to the lab. (Personally, it is the best blood draw I ever experienced…) The lab will mail your results to you and you can bring them in for interpretation.

Bringing these results to your appointment will provide a better perspective on your current state of health.

Again, thank you for choosing my services.

Please answer the following questions; once you have completed the questionnaire please return it to Dr. Manfredini, D.N. prior to your appointment.

Name_____ Date _____

Address_____ City_____ State_____ Zip_____

Phone (H)_____ (W)_____ (C)_____

Email_____

Can I put you on my wellness email distribution list? Y N

Age_____ Birth-date_____

Nearest Relative_____ Phone_____

Occupation_____ (full/part time?) Employer_____

Address_____ City_____ State_____ Zip_____

Insurance Co._____ Policy #_____ Group # _____

Address_____ City_____ State_____ Zip_____

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 <u>main</u> reason for coming in today? _____
   _____
2. Did this happen at work? Y N Car Accident? Y N What day did this happen? _____
3. If you have a specific health condition please describe in detail: _____
   _____
   _____

4. 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 main problem been bothering you?_____

Is your "main problem" 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?_____

Medications:

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 form 1 (lowest) to 10 (highest):_____

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

Your current approximate weight?_____ height?_____ Weight one year ago_____

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:_____

As an adult what has been your maximum weight?_____ minimum?_____
(do not include pregnancy)

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant.
1) _____ date_____
2) _____ date_____
3) _____ date_____
4) _____ date_____
5) _____ date_____

Are any of these situations continuing to impact your life? Y N

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? Y N Have you in the past? Y N
Name & Address *(give dates)*_____

Are you currently working with a doctor of conventional medicine (M.D.or D.O.)? Y N

What childhood illnesses have you had?

_____ measles	_____ mumps	_____ polio
_____ diphtheria	_____ chickenpox	_____ whooping cough
_____ rheumatic fever	_____ scarlet fever	_____ typhoid fever
_____ small pox	_____ tuberculosis	_____ mono - how long_____

Previous surgeries and hospitalizations (include dates):_____
_____
_____

Which of the following have you had and indicate "now" or "past", "how often" and "when?"

now or past	**year**	**now or past**	**year**	**now or past**	**year**
____pneumonia	_____	____diabetes	_____	____gonorrhea	_____
____tonsillitis	_____	____asthma	_____	____syphilis	_____
____ear infections	_____	____eczema	_____	____venereal disease	_____
____chronic infec.	_____	____heart disease	_____	____epilepsy	_____
____canker sores	_____	____herpes	_____	____high blood pres.	_____
____allergies	_____	____hepatitis	_____	____mononucleosis	_____
____thyroid prob	_____	____weight prob.	_____	____anemia	_____

____others:_____
_____
_____

Do you have any allergies to any drugs, herbs, foods, animals, or other? Y N
To what:_____
_____
_____
_____

Which of the following do you currently use?

	amount (how: often, much, and long)		**amount (how: often, much, and long)**
alcohol	_____	tobacco	_____
hormones	_____	coffee	_____
cortisone	_____	laxatives	_____
sedatives	_____	antacids	_____

other medications (please give full name, doseage, and how long you have been taking)

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Vitamins/Herbs/Homeopathics:

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

What is your nationality? *(please list all backgrounds and give approximate %)*_____
_____

You currently live with? _____spouse ____partner ____parents _____friends _____children _____ alone

Are you? married separated divorced___ widowed single in a supportive relationship

Do you have any children? Y N How many?_____

Ever had toxemia during pregnancy? Y N

Family History

Please list ages, health problems and if deceased, cause of death:

	Living (age?)	**Health Problems**	**Died (age?)**	**Cause**
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Mom's:				
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Dad's:				
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____

Do they have any health problems?_____

Do you have any blood relative (aunt, uncle, grandparents, parents) who has had any of the following:

____allergies	____ arthritis	____ asthma	____cancer
____diabetes	____depression	____skin disease	____heart attack
____genetic prob	____stroke	____ulcers	____cataracts
____thyroid prob	____seizures	____sickle cell	____venereal disease
____hypoglycemia	____anemia	____high blood pressure	

What is your weakest organ system and why?_____
_____

Personal Habits

What do you enjoy most in life?_____

What are your main interests and hobbies?_____

What do you worry most about in life?_____

Do you exercise? Y N If yes, what kind, how much & how often?_____
_____

Do you have a religious or spiritual practice? Y N If yes, what?_____

On a scale of 1-10, how would you rate the quality of your sleep? (10 being great)_____

Do you have problems *(falling or staying)* asleep?_____ __

How many hours do you sleep at night?_____

Do you awaken at night? Y N If yes, what time(s) do you usually wake up?_____

Do you ever sweat at night while sleeping? Y N

How frequently and how much do you sweat? little moderate a lot

Do you wake up feeling refreshed? Y N

Do you nap or rest horizontally throughout the day? Y N For how long?_____

What do you normally feel like temperature wise, compared to others? *warm cool ave.*

What are the temperatures of your hands and feet generally? *warm cool ave.*

Do you enjoy your work? Y N Do you take vacations? Y N

Are you currently in a happy satisfying relationship with someone? *very mostly somewhat not*

How often do you get colds, flu, sore throats, yeast infections during the year?_____

When you rise quickly from a sitting or lying position do you ever get dizzy? Y N
If yes, how often? *daily few times per week 1x/week 2x/month 1x/month rarely*

Female reproduction

Age of first menses_____ If periods have stopped at what age did they stop?_____

Are your cycles regular? Y N Periods begin every_____days. How long periods?_____

Are your periods *(heavy medium light)* & what color is blood? *light red dark red medium clots*

Do you have any spotting or bleeding between periods? Y N Any cramps? Y N

Do you have any premenstrual symptoms ? (circle one)
(water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings)
other_____

Number of pregnancies_____ Number of abortions_____

Number of live births?_____ Number of miscarriages_____

Any problems getting pregnant?_____

Do you get yearly PAP smears? Y N Any abnormal PAP's? Y N

Breast lumps? Y N Are you currently sexually active? Y N How often?_____

Is the (more or less) than 1 yr ago? Y N Do you use birth control? Y N

What type of birth control do you currently use?_____

Have you been physically or sexually abused? Y N

How old and how often?_____

Male Reproduction

How often do you have to get up at night to urinate?_____

Is this an increase in past few yrs? Y N

Do you have any abnormal discharge from the penis? Y N

Any veneral diseases? Y N Any prostate problems? Y N & past now

Ever have your prostate examined? Y N. When?_____

Are you currently sexually active? Y N How often?_____

Is this (more or less) than 1 yr ago? Y N Do you use birth control? Y N

What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? Y N How old and how often?_____

Digestion and Elimination

Do you have any problems with gas, bloating, or fullness after eating? Y N.

How often do you have gas, fullness or bloating after eating? *often sometimes never*

How severe?_____

Do you have gas in the abdomen? *upper part lower part both areas*

How long have you had this problem?_____

How often do you have bowel movements?_____

Do you ever have any *(blood, mucus, undigested food, black)* stools?

Any rectal itching? Y N Do you stools tend to be *formed or loose*?

How often do you have diarrhea?_____

Do you ever have alternating constipation and diarrhea? Y N

How often do you have long, think, and narrow stools? *often sometimes never*

How often do you have small & hard stools? *often sometimes never*

How often do you have yellow or light colored stools? *often sometimes never*

How often do you stools have a strong disagreeable odor? *often sometimes never*

Have you ever fasted? Y N Juice or water?_____

For how long have you fasted?_____

How did you feel while you were fasting?_____

Have you traveled outside the U.S in the last 5 yrs? Y N

Have you ever gone camping in the last 5 yrs? Y N

Kidneys and bladder

Have you had recurrent bladder infections? Y N

How were they treated?_____

How many bladder infections have you had in the last 3 yrs?_____

Do you have any burning sensation during or after urination? *past present*

Is your urine *dark yellow bright yellow cloudy pale clear*?

Does your urine have a strong odor to it? Y N

Do you have difficulty perspiring? Y N Do you have difficulty perspiring? Y N..

Do you perspire when you exercising? *lightly moderately heavily*

Do you perspire other times when exercising? Y N When?_____

Does your perspiration have a strong smell? Y N

Does your temperature tend to run *(low high average)*compared to others?

Occupational/household

How long have you lived at your present address?_____

Where have you lived previously?_____

(Please describe location, if old or new place i.e., new construction, dump or moldy)

Do you have specialized air filtration at home? Y N

Do you live in the city? Y N Do you work in an office building? Y N

Do the windows open? Y N

Do you specialized air filtration at your work place? Y N

Do you work in the presence of toxic fumes or chemicals? Y N

Do any of your hobbies involve toxic materials? Y N

Are you exposed to second hand smoke currently? Y N

What do you use for your drinking water? *bottled filtered tap water*

Agreement and Signature:

I understand that I am responsible for payment in full to Dr. Robert 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 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 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 February 2011