 Dr. Robert Manfredini, D.N.

**N**aprapathy &**W**ellness

Confidential Health History Summary

Date:

Name:

Address:

City:

State:

Zip:

Phone (C):       (W):       (H):

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:

**Right now, I only submit to BCBS PPO insurance. Sorry for the inconvenience.**

***Please provide BCBS PPO card to staff for scanning.***

Policy/I.D. #:

Group #:

Address:

City:

State:

Zip:

Spouse’s Policy?  Yes  No Name:       Birth Date:

How did you hear about me?

If it was a referral, who?

Referral’s Phone:

Last health practitioner seen?

When?

Address:

City:

State:

Zip:

Phone (O):       (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:
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 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 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:

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

Automobile Accident:  Y  N If so, when:       Outcome:

Slip & Fall Accident:  Y  N If so, when:       Outcome:

Cancer Treatment:  Y  N If so, when:       Outcome:

Athletic Injury:  Y  N If 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 April 2020***

**Office Use only:**

Scanned:

Birthday list:

Pt Contact list:

Address list:

PostCard list:

Email list:

Contact info