Jeffrey G. Donatello, C.N.S., D.C, C.F.M.P.
CONFIDENTIAL PATIENT INFORMATION

Date: _____ Email Address: _____
Full Name: _____
Name of Wife, Husband, or Guardian: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: ( ) _____ Cell Phone Number: ( ) _____
Birth Date: _____ Male: _____ Female: _____ Marital Status: S ___ M ___ D ___ W ___
Social Security Number: _____ - _____ - _____ Number of Children: _____ Currently Pregnant? _____
Occupation: _____
Employer's Name/Phone #: _____
Spouse's Occupation/Employer: _____
Name and Phone # of Emergency Contact: _____
How did you hear about our office? _____
Appointment Reminders? ☐ Voice Home ☐ Voice Cell ☐ Text ☐ Email ☐ None

INSURANCE INFORMATION

Primary Insurance Co. _____
Subscriber's Name _____
Relationship to Patient _____
Subscriber's Birth Date _____
Subscriber's SS# _____
Subscriber's Employer _____
Is patient covered by additional insurance? _____ Yes _____ No

Secondary Insurance Co. _____
Subscriber's Name _____
Relationship to Patient _____
Subscriber's Birth Date _____
Subscriber's SS# _____
Subscriber's Employer _____

Primary Complaint(s)_____

Present Symptom(s)_____

When Symptoms Started_____/_____/_____ How Symptoms Started_____

Severity of Pain from 1 (mild pain) to 10 (severe pain): _____

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List **ALL** medications and supplements you take. (Prescription & over-the-counter, use additional paper if needed)

Drug Name:	Dosage:	How long have you taken & for what conditions?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check **ALL** (symptoms/pain) you may have had or do have now:

___ADD/ADHD
___Alcoholism
___Allergy
___Alzheimer's
___Anemia
___Appendicitis
___Asthma
___Arthritis
___Back Pain
___Cancer
___Celiac Disease
___Chronic Fatigue
___Constipation
___Depression
___Diabetes
___Diarrhea
___Eczema
___Emphysema
___Epilepsy/seizures
___Fibromyalgia
___Gall Bladder
___Goiter
___Gout
___Headaches
___Heart Attack
___Heart Disease
___Hepatitis
___High Blood Pressure
___High Cholesterol
___High Blood Sugar
___HIV/AIDS
___Irregular Periods/Cramps
___Irritable Bowel
___Kidney infections/stones
___Low Blood Pressure
___Low Blood Sugar
___Lyme Disease
___Lupus
___Migraine
___Miscarriage
___Multiple Sclerosis
___Neck Pain
___Parkinson's
___Pneumonia
___Raynaud's
___Rheumatoid Arth.
___Ringing in ears
___Sinus infection
___Stroke
___Thyroid Problems
___Ulcers
___Vertigo/Dizziness

Do you consume any of the following? (Leave blank what doesn't apply)

Tobacco products (packs/day) _____ how many years? _____
Alcohol drinks/day _____ how many years? _____

Primary Complaint: _____

When did your complaint first begin? _____

What makes your problem better? _____

_____

What makes your problem worse? _____

_____

Describe the type of pain/symptoms you experience: _____

_____

Where exactly is the complaint area? _____

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ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Donatello all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above name doctor may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. In addition, I give Dr. Donatello consent to treatment utilizing the recommended care.

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Donatello's staff may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount paid directly to Jeffrey G. Donatello, DC, LLC, will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. **I also understand that if I suspend or terminate my care and treatment, fees for professional services rendered to me will be due immediately and payable at the regular fee schedule.**

Patient Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I have been asked/received a copy of the HIPAA Privacy Regulations and understand that my private healthcare information is protected.

I authorize Dr. Jeffrey Donatello to release information regarding the above named patient to: (name, telephone number, relationship to patient, example: mother, father, spouse, etc., please note that ONLY THE NAME LISTED will be able to obtain medical information about you.

*May we leave a message for you on your answering device? Yes _____ No _____

I HAVE READ AND FULLY UNDERSTAND THAT THE ABOVE CONSENT IS AUTHORIZATION FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION AND INSURANCE PAYMENTS.

Patient Signature _____ Date: _____

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Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

Please circle the appropriate number on all questions below. (0- 3: 0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely	0 1 2 3
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

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III

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 fruits and vegetables	0 1 2 3
Undigested food found in stools	0 1 2 3

Category IV

Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	Yes No

Category V

Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow start 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

Category VI

Crave sweets during that 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 light-headed if meals are missed	0 1 2 3

Category VII

Tired/sluggish	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3
Require excessive amounts of sleep	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Outer third of eyebrows thin	0 1 2 3
Thinning of hair on scalp, face, or genitals, or	0 1 2 3
Excessive hair loss	0 1 2 3
Mental sluggishness	0 1 2 3

Category VIII

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 IX

Do you experience vertigo or dizziness?	Yes No
Difficulty with balance?	Yes No
Difficulty concentrating?	Yes No
Short-term memory loss?	Yes No
Driving causes fatigue/headaches?	Yes No
Computer work causes fatigue/headaches?	Yes No
Has your handwriting changed in recent years?	Yes No