Natural Health Improvement Center

1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442 • nhicenters.com

NEW PATIENT INFORMATION FORM

Please print clearly:

Name: _____ Date: ___ / ___ / _____

Address: _____

City: _____ State: ___ Zip: _____

Primary Phone: _____ ○ Mobile ○ Home ○ Work ○ Other

Secondary Phone: _____ ○ Mobile ○ Home ○ Work ○ Other

Tertiary Phone: _____ ○ Mobile ○ Home ○ Work ○ Other

E-mail Address: _____

Date of Birth: ___ / ___ / _____ Age: ___ Gender: ○ Male ○ Female Height: _____ Weight: _____

How did you hear about us?

Occupation: _____ Employer: _____

Overall Health: ○ Excellent ○ Good ○ Fair ○ Poor ○ Other _____

Chief complaint (reason you are here | use notes page if need be):

What would be the personal benefit to having the above health situation handled?

Natural Health Improvement Center

1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442 • nhicenters.com

NEW PATIENT INFORMATION FORM

Previous treatments for this complaint?

Other complaints or problems: (use separate sheet if needed)

Current medications/drugs being taken: (use separate sheet if needed)

Are you currently under the care of a physician or other health care professionals? ○ Yes ○ No
(If yes, please give name and date of last visit):

Name: _____ Date of Last Visit: ___ / ___ / ___

Are you currently taking any Nutritional supplements? ○ Yes ○ No
(If yes, list them below):

Do you smoke, drink coffee or alcohol? *(if yes indicate how much)*

☐ Cigarettes ☐ Coffee ☐ Alcohol

Natural Health Improvement Center

1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442 • nhicenters.com

NEW PATIENT INFORMATION FORM

List any major illnesses *(with approx. dates)*:

List any surgery or operations with approx. date:

Past Accidents or injuries:

Marital Status: ○ S ○ M ○ D ○ W Name of Significant Other: _____

Describe their health:

Number of children, if any:

Name of Child	Age	Gender	Any health situations/concerns

Natural Health Improvement Center

1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442 • nhicenters.com

NEW PATIENT INFORMATION FORM

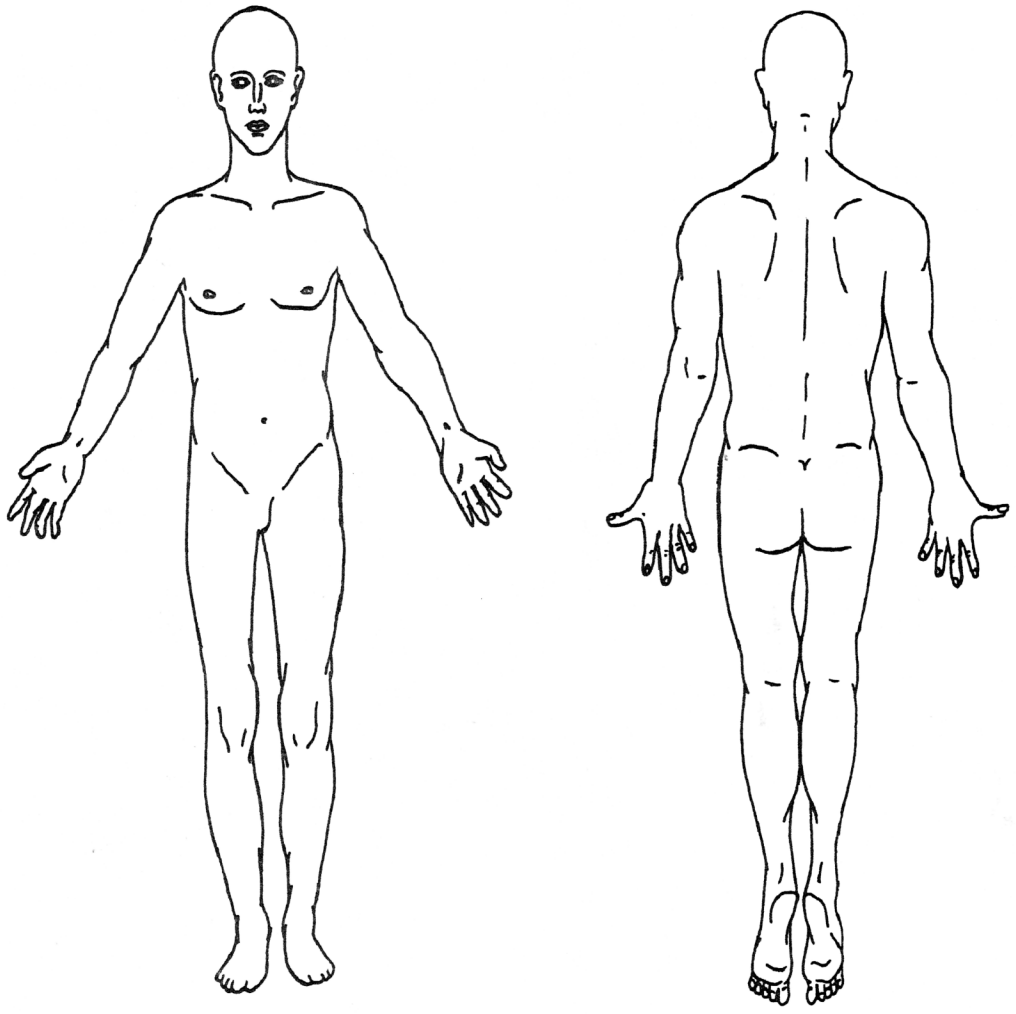
Any family history of serious illnesses ☐ Cancer ☐ Diabetes ☐ Heart ☐ Other *(List Below)*

What can we do to make you happier?

If we were to do media promotions, which source would you most likely to see them? *(Check all that apply)*

☐ Facebook ☐ Instagram ☐ Text ☐ E-mail ☐ Bulletin Board ☐ Mailed Letters ☐ Mailed Postcards ☐ Other

Please note anywhere you have a scar, tattoo, piercing etc with an X:



Notes: *(Anything that wasn't covered above, or use if needed to expand on any section above. Note which section its from.)*

The above is true to the best of my knowledge:

Print (Patient Name)	Patient Signature *(Parent/Guardian, if under 18)*	Date

PERMISSION & AUTHORIZATION FORM

Natural Health Improvement Center

1171 NE Cleveland Street • Clearwater, FL 33755 • 727-447-6442 • nhicenters.com

NEW PATIENT INFORMATION FORM

I specifically authorize Scott Damanti, DC to perform the necessary exams required by the FL Dept of Health and this facility in order to create a natural health improvement program for me (which may include but is not limited to chiropractic adjustments, dietary/lifestyle guidelines, nutritional supplements, etc.) in order to assist me in improving my health, **and not for the treatment or cure of any disease.**

I understand that these procedures are **safe, non-invasive, natural methods** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems.

I understand that these procedures are not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this analysis or any natural health, nutritional or dietary programs recommended, but rather I understand that these are means by which the body's natural responses can be used as an aid in determining possible imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

I have also read, understand and agree to Dr. Damanti's **PRIVACY POLICY & HIPPA STATEMENT.**

This form applies to this and subsequent visits / consultations.

Print (Patient Name)	Patient Signature *(Parent/Guardian, if under 18)*	Date