NUTRITION
Patient Information

25 Smith Street, Suite 202, Nanuet NY 10954
Phone: 845-623-6333 Fax: 845-684-2640
www.HudsonHealthSpine.com

Welcome New Patient,

Dr. Joseph Taccetta's mission is to provide our community with an individualized and integrated approach to natural healthcare. The core principles of this treatment are to address the root cause of the physical ailment and to facilitate the body's abilities to heal and function more efficiently. His goal is to guide and empower his patients to maintain a healthy and active lifestyle.

Before Your First Appointment:

1. Please have a copy of your most recent annual blood work and any related diagnostics faxed directly to our office. Fax number: 845-684-2640
2. Please complete the enclosed paper work and bring it with you on the date of your appointment.

The initial consultation fee is $150 in addition to any whole food nutritional supplements and dietary guidelines that may be recommended to address your specific health profile. The initial consultation will take approximately 60- 90 minutes.

If you are unable to keep this appointment, please call us at (845) 623-6333 at least 24 hours prior to your appointment to reschedule. If you cancel the appointment within 24 hours, cancellation fee $50.00 will be applied. Our office schedule for an hour of time for your appointment.

Thank you for choosing Hudson Health & Spine. We look forward to improving your health.

Best in Health,

Joseph Taccetta, D.C.
Doctor of Chiropractic
Whole Food Nutritionist

Revised 8.2019

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● DATE
_____/_____/_____

● How did you hear about our office? □ Internet □ Family □ Friend □ Sign
□ Promotion: _____ □ Patient: _____ □ Other:_____

PATIENT INFORMATION			
Name:		Sex: M / F	DOB: / / Age:
SSN: - -	E-mail:		
Home Phone :	Cell Phone:		Carrier:
I agree to receive Mobile Phone Text for an appointment reminder: □ Yes □ No		Preferred Number : □ Home / □ Mobile	
Home address:	City:	State:	Zip:
Occupation:	Employer:	Work Phone:	
Work address:	City:	State:	Zip:

● **EMERGENCY CONTACT:** _____ Relationship:_____ Phone : _____

● **PRIMARY CARE PHYSICIAN**:_____ Phone :_____

Office Address:_____City_____State_____Zip_____

● **CHECK OR CIRCLE ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY & CURRENT SYMPTOMS**

[ ] Allergies _____
[ ] Anemia
[ ] Arthritis:_____
[ ] Asthma / Difficulty Breathing
[ ] Bladder Infection
[ ] Bruise Easily
[ ] Buzzing/Ringing Ears
[ ] Cancer:_____
[ ] Chest Pain / Heart Trouble
[ ] Cold, Tingling Extremities
[ ] Constipation / Diarrhea
[ ] Convulsions / Epilepsy
[ ] Depression / Anxiety
[ ] Diabetes: Type I / II
[ ] Disc Problems: Cervical / Lumbar
[ ] Dizziness / Vertigo
[ ] Ear Infections
[ ] Fainting
[ ] Fatigue
[ ] Fever
[ ] Gallbladder Symptoms
[ ] Gout
[ ] Hand / Arm / Shoulder Pain
[ ] Headaches / Migraine
[ ] Heart Attack
[ ] Hepatitis / Liver Problems
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Hip Pain
[ ] Indigestion / Stomach Problems
[ ] Insomnia / Trouble Sleeping
[ ] Joint Pain :_____
[ ] Kidney Problems
[ ] Loss of Energy / Fatigue
[ ] Loss of Memory / Concentration
[ ] Loss of Smell / Taste
[ ] Lyme Disease
[ ] Menstrual Pain / PMS
[ ] Multiple Sclerosis
[ ] Neck / Mid-back / Low back Pain
[ ] Numbness _____
[ ] Osteoporosis / Osteopenia
[ ] Pain Down Arms / Legs
[ ] Pinched Nerves_____
[ ] Poor Circulation
[ ] Poor Posture
[ ] Scoliosis
[ ] Sinus Problems
[ ] Stroke_____
[ ] Stress / Tension
[ ] Thyroid Problems : Hypo / Hyper
[ ] Tuberculosis
[ ] Venereal Disease
[ ] Vision Blurred
[ ] Weight Loss
[ ] Other _____

IF YOU CHECKED OR CIRCLED ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

_____

● **PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1. Are you currently pregnant? □ No □ Yes • Previous Pregnancies? _____

2. Exercise: □ NONE / □ Light(1-2/week) / □ Moderate(3-4/week) / □ Daily(5-6/week)

• What type : Cardio / Yoga / Pilates / Weights / Other: _____

3. Previous Hospitalizations: □ None □ Yes : _____

_____

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4. Previous Surgeries: □ None

_____

_____

5. Previous Significant Illnesses: □ None

_____

_____

6. List of prescription or over-the-counter medication you are currently taking or have taken in the last year.

Product	Symptoms	Dosage

7. List any vitamins, supplement, herbs, or homeopathic medicines you are currently taking or have taken in the last year.

Product	Symptoms	Dosage

8. Check the following items which apply to you and indicate the amount used:

□ Coffee/Tea _____ □ Artificial Sweetener _____ □ Ice Cream _____
□ Soda _____ □ Antacids _____ □ Alcohol _____
□ Energy Drinks _____ □ Laxatives _____ □ Tobacco Products _____
□ Juices _____ □ Candy _____ □ Illicit Drug Use _____

9. Family History: □ Cancer □ Diabetes □ High Blood Pressure
□ Heart Problem □ Stroke □ Rheumatoid Arthritis

● CHIEF COMPLAINT (REASON OF YOUR VISIT)

▪ What are the Primary Symptoms that prompted today's visit? _____

▪ Have you seen any other healthcare provider for these problems? □ No □ Yes _____

▪ When did you first experience the problems that prompted your visit? _____

ACCOUNT INFORMATION & TERMS OF ACCEPTANCE

I hereby give my authorization to provide nutritional guidance to myself or my minor herein on this form. I authorize the release of my information as required to process any nutritional advice, coordination of care, and payment. I clearly understand that all services rendered to me are my personal financial responsibility. I also understand that a nutritional program or any recommended supplementation given to me does not replace the need of medical treatment and advice from my physician. If I am unable to keep a future appointment, I will inform the office at least 24 hours in advance. I aware cancellation fee if I cancel my appointment within 24hours. Payment in full is expected at the time of services. **I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information.**

X _____ _____ _____

Name of Patient (Print) Signature of Patient/ Legal Representative Date

_____

Name of parent/Guardian if patient is a minor (Print)

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Hudson Health & Spine is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

This office uses and discloses your protected health care information for the following reasons:

- to share with other treating healthcare professionals regarding your healthcare.
- to submit to your insurance company or Workers Compensation claim to verify that treatment has been rendered.
- to determine patient's benefits in a health care plan.
- to assist in overcoming a language barrier when caring for a patient.
- to notify a family member or caretaker about your health condition or in the event of an emergency situation.
- as required by State, Federal or Public Health Law
- if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence.
- appointment date and time reminder to household members or answering machines.

Any other uses or disclosure will only be made with your specific written prior authorization.

PATIENT'S RIGHTS:

You have the right to:

- revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- speak to our privacy officer who is Dr. Joseph Taccetta and can be reached at 845-623-6333 regarding privacy issues
- inspect, copy and amend your protected health information as allowed by law.
- request to receive confidential communications from us by alternative means or at an alternative location.
- obtain an accounting of any disclosures or to be notified of any breech of privacy of your protected health information.
- render a complaint to our privacy office or Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may obtain an updated copy at any time upon request.

I acknowledge that I have received and reviewed this notice with full understanding.

X_____ _____ _____

Name of Patient (Print) Signature of Patient/ Legal Representative Date

_____

Name of parent/Guardian if patient is a minor (Print)

RELEASE OF MEDICAL RECORDS:

I hereby give authorization for the release my medical records to Hudson Health & Spine.

X _____ _____ _____

Name of Patient (Print) Signature of Patient/ Legal Representative Date

_____

Name of parent/Guardian if patient is a minor (Print)