PLEASE PRINT CLEARLY

Name: ____ Date: ___________

Address: ____ Apt. #: __________

City: _____________________________ State: ________________ Zip: ____________

Shipping Address: ____

Home Phone: (   ) _______ - _____________ Cell Phone: (   ) ______ - __________

Email Address: _____________________________@____________________________

Easiest place to reach you _____________________ May we leave a message? Y N

REFERRED BY: ____

Occupation: ________________________________ Employer: ____________________

Date of Birth: _____/______/______ Age: ______ Height: ________ Weight: ________

Overall health (circle one): Excellent / Good / Fair / Poor / Other: __________________

Chief complaints (reason why you are here):

____

____

____

Previous treatments for complaints:

____

____

Current medications or drugs (include dosages):

____

____

____

Are you currently taking vitamins, herbs or nutritional supplements? If yes, please list:
____
____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):
____

Are you a vegetarian / vegan? (Please circle which one)

Personal Habits: Do you use the following and if so, how much?
Cigarettes: ________________________ Coffee: ____________________________
Alcohol: _____________________ Soda: _____________ Sugar: _______________
Non-prescription drugs: ____
____

HEALTH HISTORY

List any major illnesses, injuries, surgeries (with approx. dates):
____
____
____
____

Any major scars or body piercings (please list):
____
____

Number of pregnancies: ________________ Are you currently pregnant? Y N

Marital status (please circle): Single Married Divorced Widowed

Name of spouse or partner: _________________________

Describe health of spouse or partner: _______________________________________
____

Number of children _________ Any concerns or health issues (please list):
____
____
____

Any family history of serious illnesses (circle those which apply):
Cancer Diabetes Heart Stroke
Other:
____
____

Any household pets or other animals you or family members are in close contact with:
____

How can we help you? ____
____

SIGNED: ____ **DATE**: ______________

PERMISSION AND AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING

Please read before signing

I specifically authorize the natural health practitioner to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me, which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not the for treatment, or "cure" of any disease.**

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these could cause or contribute to various health problems. I understand that **Nutrition Response Testing is 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 Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is means by which the body's natural reflexes can be used as an aid for determining possible nutritional 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. This permission form applies to subsequent visits and consultations.

DATE: ______________
PRINT NAME: ____
SIGNED: ____