NEW PATIENT INFORMATION FORM

Name:			Date:
Address:			
Shipping address (if different):			
Best Phone Number:	Alternate number:		
Email address:			
Referred by:			
Occupation:	Employer:		
Date of birth:	Age:	Male ☐ Female ☐	
	Height:	Weight:	
Overall health: (excellent, good, fair, poor…explain)			
Chief complaint (reason you are here):			
Previous treatment for this complaint:			
Other complaints of problems:			
ALL medication, drugs, or nutritional supplements you are currently taking or have take recently. Please be as thorough as possible.			
Are you currently under the care of a physician or other health care professionals?(if yes, please give name and date of last visit)			
How often do you:	Smoke?	Drink coffee?	Drink alcohol?

Use this space to add any other information you want us to know:

NEW PATIENT INFORMATION FORM

Name:	Date:
Health History:	
List any major illnesses with approximate date:	
List any surgery or operations with approximate date:	
Past accidents or injuries:	
Marital status: S☐ M☐ D☐ W☐	Name of spouse:
Describe health of spouse:	

Number of children if any:			
Name of Child	Age	F/M	Any Physical Condition
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	
		F☐ M☐	

Any family history of: ☐Cancer ☐Diabetes ☐Heart disease ☐Other:
Any pets?
How can we make you happier?

Chiro-Center
Natural Health Improvement

2323 Naperville Rd #180, Naperville, IL 60563 Phone 630-955-0485

PEREMISSION & AUTHORIZATION FORM
FOR
NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING

I specifically authorize the natural health practitioners at the Chiro-Center to perform a Nutritional Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, and other life style recommendations in order to assist me in improving my health, **not for the 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 what deficiencies of imbalances in these areas 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.

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 a means by which the body's natural reflexes can be used as an aid to 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 forgoing. This permission for applies to subsequent visits and consultations:

Date:
Name:
Address:

Phone:

Signature: (by filling this line you are signing it)

If minor, relationship of person signing: