WHOLE BODY HEALTH

New Patient Information Forms_

Name_____ Date_____

Address_____Apt #_____

City_____State_____Zip Code_____

Mailing/Shipping Address (if different)_____

Home Phone (_____)_____Work or Cell Phone(_____)_____

Email Address:_____

REFERRED BY:_____

Occupation:_____Employer:_____

Date of Birth:_____ Age_____ Sex: F / M Height_____ Weight_____

Overall Health: (circle one) Excellent / Good / Fair / Poor / Other:_____

Chief Complaints (reason you are here)

_____

_____

Previous Treatments for this
complaint:_____

_____

Current Medications/drugs you are
taking:_____

_____

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

Nutritional Supplements currently taking:_____

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

Cigarettes:_____ Coffee_____Alcohol_____

Name_____ Date_____

HISTORY:

List any major illnesses (with approx. dates):

_____

_____

List any surgery or operations (with approx. dates):_____

_____

Past Accidents or Injuries: _____

……

Marital Status: S M D W Name of Spouse: _____

Number of children:_____

Name of Child	Age	Sex	Any physical concerns or conditions?
_____	_____	F / M	_____
_____	_____	F / M	_____
_____	_____	F / M	_____

Any family history of serious illnesses such as cancer, diabetes, heart, etc. (list any)

_____

Any household pets or other animals you or family members are in close contact with?_____

What can we do to make you happier?

_____

_____

SIGNED_____ Date_____

WHOLE BODY HEALTH

PERMISSION & AUTHORIZATION FORM REGARDING

THE USE OF NUTRITION RESPONSE TESTING

Please read before signing:

I specifically authorize the natural health practitioner at WHOLE BODY HEALTH to perform a Nutrition Response Testing health analysis and to develop a natural health improvement program for me. This may include specific dietary guidelines and nutritional supplements to assist me in improving my health, **and 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 that deficiencies or 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, 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 a means by which the body's natural reflexes can be used as an aid in 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:_____

Signature:_____

(If minor, signature of parent or guardian is required)

Witness: _____ Date_____