

Nutrition Intake Form

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

Phone Number (____) _____ (____) _____ (____) _____
Home Cell Work

E-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height ____ Weight ____

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

Chief complaint (reason you are here): (use separate sheet if more room needed) _____

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? _____

(If yes, please give name and date of last visit): _____

Nutritional supplements you are taking: _____

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

Cigarettes _____ Coffee _____ Alcohol _____

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Office Use Only:

Nutrition Intake Form

Name: _____ Date _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

HISTORY:

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 Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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_____	_____	M/F	_____
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Any family history of serious illnesses (check those which apply): Cancer Diabetes Heart Other _____

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

What can we do to make you happier? _____

SIGNATURE: _____ DATE _____

Nutrition Intake Form

1. Chief Concerns: _____

2. Medications and/or Nutritional Supplements currently on: _____

3. Dietary Intake for 2 days before appointment:

Day 1

Day 2

Breakfast: _____ Breakfast: _____

Snacks: _____ Snacks: _____

Lunch: _____ Lunch: _____

Snacks: _____ Snacks: _____

Dinner: _____ Dinner: _____

Snacks: _____ Snacks: _____

**PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF
NUTRITION RESPONSE TESTING®**

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Synergy Holistic Health Center 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 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 imbalance 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 organ responses 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.

By my signature, I acknowledge that I have read and I understand the questions and information on this Nutrition Intake Form.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: (____) _____ - _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Signature: _____

(If minor, signature of parent or guardian required)

Witness: _____