WILLAMETTE VALLEY HOLISTIC NUTRITION

DESIGNED CLINICAL NUTRITION

1042 Main Street • Dallas OR 97338 • (503) 435–7799 • wvholisticnutrition.com

NEW CLIENT INFORMATION FORM

Please print clearly:

Name____ Date ___________

Address ____ Apt# ___________

City ______________________________ State ____________ ZIP ____________

Primary Phone ______________________ Secondary Phone ______________________

E-mail ____

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): ____

____

Previous treatments for this complaint ____

____

Other complaints or problems: (use separate sheet if needed) _______________________

____

Current medications and supplements 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):

____

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

Cigarettes ______________ Coffee ___________________ Alcohol ________________

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Office Use Only:

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HISTORY:

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

____

List any surgery or operations with approx. dates: _______________________________________

____

Past accidents or injuries: ____

____

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Marital Status: S M D W Name of Spouse _____________________________________

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

Name of Child	Age	Sex	Any health situations or concerns?
______________________________	_____	M/F	______________________________________
______________________________	_____	M/F	______________________________________
______________________________	_____	M/F	______________________________________

Any family history of serious illnesses (circle 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? ____

____

SIGNED: ____ DATE: ___________________

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

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Willamette Valley Holistic Nutrition to perform a Nutrition Response Testing health analysis in order to create a natural 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 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.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: ____________________________________

Print Name: ____

Signature: ____

(*Parent/Guardian, if under 18*)