



WILLAMETTE VALLEY HOLISTIC NUTRITION

DESIGNED CLINICAL NUTRITION

289 E Ellendale Ave Suite 101 • Dallas OR 97338 • (503) 435-7799 • wvholisticnutrition.com

NEW CLIENT INFORMATION FORM

Page 1 of 2

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 _____

=====

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: _____

=====

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)