NUTRITION RESPONSE TESTING

NEW PATIENT INFORMATION

Bertram Healing Center
1460 W HWY 29, Suite A
Bertram, TX 78605

❶ PATIENT DEMOGRAPHIC INFORMATION

Last Name: | **First Name:** | **MI** | **Date of Birth:** | **Age:** | **Sex:** ☐ Male ☐ Female

Spouse's First Name: | **Nickname:** | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Minor ☐ Separated ☐ Widowed ☐ Partnered

Mailing Address: | **Address Status:** ☐ Permanent ☐ Seasonal | **Local Home Phone:** ( )

City, State, Zip Code: | **Best Way to Reach You:** ☐ Home ☐ Cell ☐ Work | **Cell Phone:** ( )

Employment Status: ☐ Retired ☐ Employed ☐ Student ☐ Unemployed | **Employer:** | **Job Title:** | **Work Phone:** ( )

Referred by: ☐ Family ☐ Friend ☐ Health Care Provider ☐ Online Search ☐ Facebook ☐ Other | **Name of Person Referred:**

Email Address:

❷ IN CASE OF EMERGENCY

Name of local friend or relative: | **Relationship to Patient:** | **Phone:** ( )

Name of your family physician: | **Phone:** ( ) | | **Phone:** ( )

❸ HEALTH HISTORY/LIST PREVIOUS DIAGNOSIS:

Patient History: Place a mark in the box next to each condition you have or have had in the past. ☐ None Apply ☐ See Attached

- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Antibiotic Use
- ☐ Autoimmune
- ☐ Corticosteroid Use
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness
- ☐ High Blood Pressure
- ☐ Fatigue
- ☐ Gall Bladder
- ☐ High Cholesterol
- ☐ Headaches
- ☐ Heart Disease
- ☐ History of Neck Pain
- ☐ History of Back Pain
- ☐ Hormones
- ☐ Stroke
- ☐ Skin Problems
- ☐ Thyroid Problems
- ☐ Weight Gain
- ☐ Pregnant - # weeks:_____

Family History: ☐ Cancer ☐ Cardiovascular Problems ☐ Diabetes ☐ High Blood Pressure ☐ None Apply

Relevant Incidents:	Description:	Date:
☐ Recent Injuries		
☐ Surgeries		

Number of Births:_____ **Number of C-sections:**_____

❹ MEDICATIONS

Do you take medications? ☐ Yes ☐ No

If Yes, List Below or ☐ See Attached

❹A SUPPLEMENTS

Do You Take Vitamins, Herbs, Supplements or Minerals? ☐ Yes ☐ No

If Yes, List Below or ☐ See Attached

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Patient Name: **Date:**

❺ LIST CURRENT COMPLAINTS:

1.
2.
3.
4.
5.

What Activities Does Discomfort Interfere With?
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

How Often Do You Experience Your Symptoms?
☐ Constantly (76% - 100%) ☐ Frequently (51%- 75%)
☐ Occasionally (26% - 50%) ☐ Intermittently (0 - 25%)

❺A MAIN HEALTH GOALS:

1.
2.
3.
4.
5.

What Relevant Tests Have You Had Done?
☐ None ☐ X-rays ☐ MRI ☐ CT Scan ☐ Labs

Who Have You Seen for Symptoms?
☐ No One ☐ M.D. ☐ Physical Therapist
☐ Acupuncturist ☐ Nutritionist

Rate How You Feel Today
☐ 0 No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unbearable Pain

❻ HEALTHY LIVING

What kind of exercise do you do?

When do you exercise? ☐ AM ☐ PM ☐ Lunchtime ☐ Weekends Only | **How long is your workout?**

Number of fruit servings per day: _____ Breakfast _____ Lunch _____ Dinner _____ Snack

Number of vegetable servings per day: _____ Breakfast _____ Lunch _____ Dinner _____ Snack

Number of 8oz glasses of water per day: 1 2 3 4 5 6 7 8 9 10 | **What is your can't live without favorite food?** | **Diet:**

How Many Times a Week Do You Eat Out? | **How Many Times a Week Do You Eat Fast Food?**

Number of Alcoholic drinks per week ____ | **Number of cups of coffee per day** ____ | **Number of Sodas per day** ____

Hours of sleep per night? 5-6 6-7 7-8 8 or more | **Difficult going sleep?** ☐ Yes ☐ No | **Difficult staying asleep?** ☐ Yes ☐ No

Stress (Scale of 1 to 6 with 6 being the highest)

Work	Kids	Friends	Family	Money	Health
1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6	1 2 3 4 5 6

How positive are you? 1 2 3 4 5 6 7 8 9 10 | **How healthy do you think you are?** 1 2 3 4 5 6 7 8 9 10 | **Do you want to lose weight?** ☐ Yes ☐ No

❼ PAYMENT (payment is due at the time of service)

☐ **I understand that I must provide 24 hours notice to cancel or reschedule an appointment, and that if I do not, charges will still apply.**

The information provided on this form is true to the best of my knowledge, and I will inform you of any changes in my health, demographics or insurance when applicable. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release information required to process my claims and that, otherwise, it will be kept confidential in accordance with state law.

Patient /Guardian Signature: **Date:**