Nutrition Response Testing® NEW PATIENT INFORMATION FORM

Name: ______________________________ Date: ______________

Address: ____

City__________________ State_______ ZIP ________

Home Phone (____) _____-__________ Cell Phone (____) _____-__________

Email address: ____

REFERRED BY:____

Date of Birth: ______________ Age: ______ Sex: M/F Height ________ Weight ________

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

Chief complaints (reasons you are here):

1.____

2.____

3.____

4.____

5.____

Previous treatments for these complaints:____

____

____

Other complaints or problems: ____

____

Current medications/drugs being taken: ____

____

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: _______________________

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

____

List any surgery or operations (with approximate dates): ____

____

Past Accidents or injuries: ____

____

Marital Status: S M D W Name of Spouse (if married): ______________________________________

Describe health of spouse:_____________________________________ Number of children if any: ____________

Name of Child	Age	Sex	Any physical conditions 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: _________________________________