

Wellness

Nature's Way

Please fill out this form **completely and accurately**. This information is essential to helping the doctor to develop a safe and effective program that addresses your needs, goals and interests. All information received on this form will be treated as strictly confidential.

Functional Nutrition Intake Form

Demographics					
First Name		Middle		Last Name	
Date of Birth		Age		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address					
City		State		Zip Code	
Preferred phone				<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	
Height			Weight		
Do you have pets?	<input type="checkbox"/> None <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other:				
Email address					
Referred by					
What are you TOP 3 health and/or nutritional concerns?					
1.					
2.					
3.					
Are you currently under the care of a physician or other health care professional?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please give name and date of last visit.					

Medical History

Please check "yes" for any diagnosed health condition and the approximate date of onset.					
CONDITION	YES	Date of Onset	CONDITION	YES	Date of Onset
GASTROINTESTINAL			INFLAMMATORY/ AUTOIMMUNE		
Irritable Bowel Syndrome			Chronic Fatigue Syndrome		
Inflammatory Bowel Disease			Rheumatoid Arthritis		
Crohn's Disease			Lupus SLE		
Ulcerative Colitis			Frequent Infections		
Celiac Disease			Severe Infectious Disease		
Gastric or Peptic Ulcer Disease			Herpes		
GERD, Reflux or Heartburn			Gout		
Hepatitis C or Liver Disease			Other:		
Food Intolerance			MUSCULOSKELETAL/PAIN		
Other:			Osteoarthritis		
RESPIRATORY			Chronic Pain		
Asthma			Fibromyalgia		
Chronic Sinusitis			Migraines		
Sleep Apnea			Other:		
Bronchitis or Emphysema			URINARY/REPRODUCTIVE		
Tuberculosis			Kidney Stones		
Other:			Urinary Tract Infections		
CARDIOVASCULAR			Yeast Infection		
Heart Disease/Heart Attack			Prostate Problem		
Stroke			Other:		
Elevated Cholesterol			METABOLIC/ENDOCRINE		
Irregular Heart Rate			Type 1 Diabetes		
High Blood Pressure			Type 2 Diabetes		
Other:			Metabolic Syndrome		
NEUROLOGICAL/ BRAIN			Hypoglycemia		
Depression			Hypothyroidism		
Anxiety			Hyperthyroidism		

Bipolar Disorder			Polycystic Ovarian Syndrome		
ADD/ADHD			Infertility		
Multiple Sclerosis			Other:		
Seizures			OTHER		
Anorexia Nervosa			Chronic Ear Infections		
Bulimia			Chicken Pox/Shingles		
Parkinson's Disease			Bells Palsy		
Other:			Epstein Barr		
			Mononucleosis		
DERMATOLOGICAL			CANCER: Please list type(s) and treat-		
Eczema					
Psoriasis					
Acne					
Other:					
Have you ever had an organ removed?					
Organ	YES	Date	CONDITION	YES	Date
Tonsils			Colon		
Appendix			Uterus		
Thyroid			Ovary		
Gall Bladder			Other:		
Please list other previous injuries, surgeries and hospitalizations. Provide your age and date, if known.					
Your Birth History: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section			Were you breastfed as an infant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Family History			
Have any of your close relatives (parents, sibling, child, grandparent) been diagnosed with the following? Please check, describe and provide age of onset for those that apply.			
Condition	Family Member(s)	Condition	Family Member(s)
Heart Disease		Cancer	
High Blood Pressure		Overweight	
Food Intolerances		Stroke	

Autoimmune Disease		Diabetes	
Oral History			
Do you visit a dentist twice per year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do your gums bleed when you brush your teeth, getting a pink toothbrush? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any silver/mercury amalgam fillings? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Known Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications: Please check any of the medications you are CURRENTLY taking				
<input type="checkbox"/> Antacids	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Heart Meds	<input type="checkbox"/> Steroids
<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Anti-inflammatory	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Cholesterol/Statin	<input type="checkbox"/> Testosterone
<input type="checkbox"/> Antifungal	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Diabetic/Insulin	<input type="checkbox"/> Muscle Relaxers	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Antidepressants	<input type="checkbox"/> Birth Control	<input type="checkbox"/> Estrogen	<input type="checkbox"/> Progesterone	<input type="checkbox"/> Tylenol
<input type="checkbox"/> Other:				<input type="checkbox"/> Ulcer Meds

Herb/Supplement	Year Started	Reason

Have you EVER had prolonged or regular use of?		Date
NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tylenol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acid-blocking drugs (Zantac, Pepcid, Tums etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Antibiotics > 3 times per year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Antibiotics long term (> 1 month continuously)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Lifestyle Information

Are you currently involved in an exercise program? Yes No

How often:

How many hours do you sleep on weeknights? <6 6-8 8-10 10+

How many hours do you sleep on weekends? <6 6-8 8-10 10+

Check which apply to you: Trouble falling asleep Wake up during the night Don't feel rested

Rate your stress level: None Mild Moderate High Extreme

What helps you relax?

Chemical Exposures

What is your occupation?

Are you regularly exposed to any chemicals? Yes No

Any significant past or present exposure to substances such as recreational drugs or alcohol? Yes No

If yes, please explain:

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? Yes No

Have you changed your eating habits for a health reason? Yes No

If yes, please explain:

Are you currently following a particular diet or nutrition plan? Yes No

Nutrition History continued

Do you have any eating preferences?

Vegan

Low Carb/Keto

Dairy Free

Intermittent Fasting

Vegetarian

Low/No Sugar

Gluten Free

Other:

Do you avoid any particular foods? Yes No

If yes, please explain:

Do you have any adverse food reactions (intolerances or allergies)? Yes No

If yes, please describe:

Have you recently lost or gained weight? Yes No

If yes, please describe:

Do you have or have you had an eating disorder? Yes No

If yes, please describe:

Please check the following items which apply to you and indicate amount consumed:				
<input type="checkbox"/> Coffee		<input type="checkbox"/> Candy		<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Tea		<input type="checkbox"/> Chocolate		<input type="checkbox"/> Other Tobacco
<input type="checkbox"/> Soda		<input type="checkbox"/> Ice Cream		<input type="checkbox"/> Alcohol
<input type="checkbox"/> Water		<input type="checkbox"/> Sweetener		<input type="checkbox"/> Sugar

Intake Summary	
What type(s) of protein do you consume most days of the week? (Check all that apply)	
<input type="checkbox"/> Red Meat <input type="checkbox"/> Chicken/Turkey <input type="checkbox"/> Pork <input type="checkbox"/> Soy-based <input type="checkbox"/> Dairy <input type="checkbox"/> Nuts & Seeds <input type="checkbox"/> Eggs <input type="checkbox"/> Beans	
How many servings of fruit do you have in a day?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6+
How many servings of vegetables do you have in a day?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6+
How many meals do you eat each day?	How many snacks do you eat each day?
How many meals do you buy from a restaurant or fast food per week ?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6+
How many desserts do you have in an average week?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6+
What is your favorite meal?	
Check all of the factors that apply to your eating habits and current lifestyle:	
<input type="checkbox"/> Love to eat	<input type="checkbox"/> Fast eater
<input type="checkbox"/> Love to cook	<input type="checkbox"/> Erratic eating patterns
<input type="checkbox"/> Emotional eater	<input type="checkbox"/> Eat too much
<input type="checkbox"/> Late night eater	<input type="checkbox"/> Rely on convenience foods
<input type="checkbox"/> Struggle with eating issues	<input type="checkbox"/> Eat fast food frequently
<input type="checkbox"/> Family members have different tastes	<input type="checkbox"/> Make poor snack choices
	<input type="checkbox"/> Confused about food/nutrition
	<input type="checkbox"/> Dislike healthy food
Food Diary: Please record what you eat and drink during one 24 hour period that represents a typical day. Please be sure to include all beverages, cream and sweetener added to beverages and condiments added to foods.	

What time do you wake up:	Bedtime:	Indicate the following:		
Time	Food/Beverage	Homemade	Frozen Pre-Packaged	Take out Fast Food Restaurant

WOMEN ONLY

Does your menstrual cycle occur monthly? Yes No

If yes, cycle occurs every how many days?

Period lasts how many days?

Please indicate any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Cysts | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Bloating | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Severe Cramping | <input type="checkbox"/> Mood swings/Irritability | <input type="checkbox"/> Fertility issues |
| <input type="checkbox"/> Heavy bleeding | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Fertility treatments |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Abnormal pap | <input type="checkbox"/> Other: |

MEN ONLY

Have you had a vasectomy? Yes No

Do you have a history of prostate problems? Yes No

Do you have any trouble with urination? Yes No

Have you had fertility problems? Yes No

Do you have a history of erectile dysfunction? Yes No

ALL PATIENTS- Readiness Assessment.
To improve your health, how ready/willing are you to ...

1 (not willing) to 5 (very willing)	1	2	3	4	5
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					

Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Patient Signature: _____ Date: _____

Welcome to Wellness Nature’s Way Nutrition Response Testing

In order for us to give you the attention you deserve on your path to wellness, we ask you to please be aware of our Mission, Philosophy, and Policies:

Mission: At Wellness Nature’s Way, we believe in partnering with our patients and their families to define and attain their health goals.

Philosophy: To educate and empower you to live in optimal wellness This approach is comprehensive and compliments any existing health care program.

INITIAL: POLICIES:

_____ **Tardiness:** Please be courteous and arrive on time for your scheduled appointment. Late arrivals force us to deduct time from your appointment in order to keep the schedule for other clients throughout the day. **Anyone arriving more than five minutes past their scheduled time will need to rebook their appointment.**

_____ **Cancellations:** We require a minimum of 24 hours advance notice for any cancellation or rescheduling of your appointment. This is a consideration to our practitioners. Less than 24 hour notice will result in an office visit charge.

_____ **Payment of Services:** Payment in full is expected at the time of service.

_____ **Returned Checks:** A standard fee of \$25.00 will be charged for any returned checks.

I have read and understand the office mission, philosophy and policies.

Print Name: _____ Date: _____

Signature: _____

Cancellation & No-Show Policy

At **Wellness Nature's Way Functional Medicine Clinic**, we value your time and aim to provide the highest level of care. In order to maintain the quality of our services and accommodate other patients, we kindly request that you notify us of any changes to your appointment as early as possible.

Cancellation Policy:

- Cancellations made less than 24 hours before the scheduled appointment time will result in a full charge for the service to the credit card on file.
- No-shows will also be charged the full amount of the service to the credit card on file.

We understand that unexpected circumstances may arise, and we truly appreciate your cooperation and understanding in this matter. By adhering to this policy, you help us maintain an efficient and effective scheduling system for all our patients.

Thank you for choosing **Wellness Nature's Way Functional Medicine Clinic**. We look forward to continuing to serve your health and wellness needs.

Account Type:	VISA <input type="checkbox"/>	MASTERCARD <input type="checkbox"/>	DISCOVER <input type="checkbox"/>	AMEX <input type="checkbox"/>
Cardholder Name:	_____			
Credit Card Number:	_____			
Expiration Date:	_____			
CVV:	_____			
Signature:	_____	Date:	_____	
I authorize Wellness Nature's Way to charge the credit card indicated in this authorization form according to the terms & conditions outlined above. Payment authorization is for appointments cancelled less than 24 hours from scheduled date and no shows. I certify that I am the authorized user of this credit card and I will not dispute the payment with my credit card company.				

SYMPTOM SURVEY FORM



Patient _____ Doctor _____ Date _____
 Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male Female
 Pulse: Recumbent _____ Standing _____ Vegetarian: Yes No
 Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.

- ○ ○ MILD symptoms (occurred once or twice last 6 months).
- ● ○ MODERATE symptoms (occurred once or twice last month).
- ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
- ○ ○ Leave circles BLANK if they don't apply to you!

1 2 3 GROUP 1

- 1 ○ ○ ○ Acid foods upset
- 2 ○ ○ ○ Get chilled often
- 3 ○ ○ ○ "Lump" in throat
- 4 ○ ○ ○ Dry mouth-eyes-nose
- 5 ○ ○ ○ Pulse speeds after meal
- 6 ○ ○ ○ Keyed up - fail to calm
- 7 ○ ○ ○ Cut heals slowly
- 8 ○ ○ ○ Gag easily
- 9 ○ ○ ○ Unable to relax; startles easily
- 10 ○ ○ ○ Extremities cold, clammy
- 11 ○ ○ ○ Strong light irritates
- 12 ○ ○ ○ Urine amount reduced
- 13 ○ ○ ○ Heart pounds after retiring
- 14 ○ ○ ○ "Nervous" stomach
- 15 ○ ○ ○ Appetite reduced
- 16 ○ ○ ○ Cold sweats often
- 17 ○ ○ ○ Fever easily raised
- 18 ○ ○ ○ Neuralgia-like pains
- 19 ○ ○ ○ Staring, blinks little
- 20 ○ ○ ○ Sour stomach often

GROUP 2

- 21 ○ ○ ○ Joint stiffness on arising
- 22 ○ ○ ○ Muscle-leg-toe cramps at night
- 23 ○ ○ ○ "Butterfly" stomach, cramps
- 24 ○ ○ ○ Eyes or nose watery
- 25 ○ ○ ○ Eyes blink often
- 26 ○ ○ ○ Eyelids swollen, puffy
- 27 ○ ○ ○ Indigestion soon after meals
- 28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
- 29 ○ ○ ○ Digestion rapid
- 30 ○ ○ ○ Vomiting frequent
- 31 ○ ○ ○ Hoarseness frequent
- 32 ○ ○ ○ Breathing irregular
- 33 ○ ○ ○ Pulse slow; feels "irregular"
- 34 ○ ○ ○ Gagging reflex slow
- 35 ○ ○ ○ Difficulty swallowing
- 36 ○ ○ ○ Constipation, diarrhea alternating
- 37 ○ ○ ○ "Slow starter"
- 38 ○ ○ ○ Get "chilled" infrequently
- 39 ○ ○ ○ Perspire easily
- 40 ○ ○ ○ Circulation poor, sensitive to cold
- 41 ○ ○ ○ Subject to colds, asthma, bronchitis

GROUP 3

- 42 ○ ○ ○ Eat when nervous
- 43 ○ ○ ○ Excessive appetite
- 44 ○ ○ ○ Hungry between meals
- 45 ○ ○ ○ Irritable before meals
- 46 ○ ○ ○ Get "shaky" if hungry
- 47 ○ ○ ○ Fatigue, eating relieves
- 48 ○ ○ ○ "Lightheaded" if meals delayed
- 49 ○ ○ ○ Heart palpitates if meals missed or delayed
- 50 ○ ○ ○ Afternoon headaches
- 51 ○ ○ ○ Overeating sweets upsets

1 2 3

- 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
- 53 ○ ○ ○ Crave candy or coffee in afternoons
- 54 ○ ○ ○ Moods of depression - "blues" or melancholy
- 55 ○ ○ ○ Abnormal craving for sweets or snacks

GROUP 4

- 56 ○ ○ ○ Hands and feet go to sleep easily, numbness
- 57 ○ ○ ○ Sigh frequently, "air hunger"
- 58 ○ ○ ○ Aware of "breathing heavily"
- 59 ○ ○ ○ High altitude discomfort
- 60 ○ ○ ○ Opens windows in closed rooms
- 61 ○ ○ ○ Susceptible to colds and fevers
- 62 ○ ○ ○ Afternoon "yawner"
- 63 ○ ○ ○ Get "drowsy" often
- 64 ○ ○ ○ Swollen ankles, worse at night
- 65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
- 66 ○ ○ ○ Shortness of breath on exertion
- 67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
- 68 ○ ○ ○ Bruise easily, "black and blue" spots
- 69 ○ ○ ○ Tendency to anemia
- 70 ○ ○ ○ "Nose bleeds" frequent
- 71 ○ ○ ○ Noises in head, or "ringing in ears"
- 72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

- 73 ○ ○ ○ Dizziness
- 74 ○ ○ ○ Dry skin
- 75 ○ ○ ○ Burning feet
- 76 ○ ○ ○ Blurred vision
- 77 ○ ○ ○ Itching skin and feet
- 78 ○ ○ ○ Excessive falling hair
- 79 ○ ○ ○ Frequent skin rashes
- 80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
- 81 ○ ○ ○ Bowel movements painful or difficult
- 82 ○ ○ ○ Worrier, feels insecure
- 83 ○ ○ ○ Feeling queasy; headache over eyes
- 84 ○ ○ ○ Greasy foods upset
- 85 ○ ○ ○ Stools light colored
- 86 ○ ○ ○ Skin peels on foot soles
- 87 ○ ○ ○ Pain between shoulder blades
- 88 ○ ○ ○ Use laxatives
- 89 ○ ○ ○ Stools alternate from soft to watery
- 90 ○ ○ ○ History of gallbladder attacks or gallstones
- 91 ○ ○ ○ Sneezing attacks
- 92 ○ ○ ○ Dreaming, nightmare type bad dreams
- 93 ○ ○ ○ Bad breath (halitosis)
- 94 ○ ○ ○ Milk products cause distress
- 95 ○ ○ ○ Sensitive to hot weather
- 96 ○ ○ ○ Burning or itching anus
- 97 ○ ○ ○ Crave sweets

GROUP 6

- 98 ○ ○ ○ Loss of taste for meat
- 99 ○ ○ ○ Lower bowel gas several hours after eating
- 100 ○ ○ ○ Burning stomach sensations, eating relieves
- 101 ○ ○ ○ Coated tongue
- 102 ○ ○ ○ Pass large amounts of foul-smelling gas
- 103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 ○ ○ ○ Mucous colitis or "irritable bowel"
- 105 ○ ○ ○ Gas shortly after eating
- 106 ○ ○ ○ Stomach "bloating" after eating

1 2 3 GROUP 7A

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

GROUP 7B

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Mental sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising, wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7C

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

GROUP 7D

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

GROUP 7E

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

GROUP 7F

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma

1 2 3

- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

GROUP 8

- 173 Apprehension
- 174 Irritability
- 175 Morbid fears
- 176 Never seems to get well
- 177 Forgetfulness
- 178 Indigestion
- 179 Poor appetite
- 180 Craving for sweets
- 181 Muscular soreness
- 182 Depression; feelings of dread
- 183 Noise sensitivity
- 184 Acoustic hallucinations
- 185 Tendency to cry without reason
- 186 Hair is coarse and/or thinning
- 187 Weakness
- 188 Fatigue
- 189 Skin sensitive to touch
- 190 Tendency toward hives
- 191 Nervousness
- 192 Headache
- 193 Insomnia
- 194 Anxiety
- 195 Anorexia
- 196 Inability to concentrate; confusion
- 197 Frequent stuffy nose; sinus infections
- 198 Allergy to some foods
- 199 Loose joints

FEMALE ONLY

- 200 Very easily fatigued
- 201 Premenstrual tension
- 202 Painful menses
- 203 Depressed feelings before menstruation
- 204 Menstruation excessive and prolonged
- 205 Painful breasts
- 206 Menstruate too frequently
- 207 Vaginal discharge
- 208 Hysterectomy / ovaries removed
- 209 Menopausal hot flashes
- 210 Menses scanty or missed
- 211 Acne, worse at menses
- 212 Depression of long standing

MALE ONLY

- 213 Prostate trouble
- 214 Urination difficult or dribbling
- 215 Night urination frequent
- 216 Depression
- 217 Pain on inside of legs or heels
- 218 Feeling of incomplete bowel evacuation
- 219 Lack of energy
- 220 Migrating aches and pains
- 221 Tire too easily
- 222 Avoids activity
- 223 Leg nervousness at night
- 224 Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Wellness Nature's Way

580-330-8038

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

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Natural Health Improvement 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.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: (____) _____ - _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

