

# ***Advanced Chiropractic Wellness Center***

20500 S. LaGrange Rd., Frankfort, IL 60423 Phone (815) 464-6772

## **PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING™**

### **PLEASE READ BEFORE SIGNING:**

I specifically authorize the natural health practioners at the Advanced Chiropractic Wellness 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 reflexes 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 \_\_\_\_\_

**ADVANCED CHIROPRACTIC WELLNESS CENTER  
NEW PATIENT INFORMATION FORM**

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**Please print clearly:**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Shipping Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

e-mail address: \_\_\_\_\_

**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): (use separate sheet if more room needed)  
\_\_\_\_\_  
\_\_\_\_\_

Previous treatments for this complaint \_\_\_\_\_  
\_\_\_\_\_

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

Current medications/drugs 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):  
\_\_\_\_\_  
\_\_\_\_\_

Nutritional supplements you are taking: \_\_\_\_\_

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

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Office Use Only:

**ADVANCED CHIROPRACTIC WELLNESS CENTER  
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Name \_\_\_\_\_ Date \_\_\_\_\_

**HISTORY:**

List any major illnesses (with approx. dates): \_\_\_\_\_  
\_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_  
\_\_\_\_\_

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 physical conditions or concerns?
_____	_____	M / F	_____
_____	_____	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 \_\_\_\_\_