Life Wellness & Chiropractic, PC

www.DrErgas.com

770.432.7676

NEW CLIENT INFORMATION FORM

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:

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Name: ____________________________________ Date_______________

HISTORY:
List any major illnesses (with approximate dates):

____

____

List any surgery or operations (with approximate date):

____

____

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 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 _______________

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New Patient Introduction Form

Patient Name:_________________________________ Date:_________________

1. Concerns:____

   ____

   ____

   ____

2. Medications and/or Nutritional Supplements:

   ____

   ____

   ____

   ____

3. Dietary Intake for past 2 days before appointment:

DAY ONE	DAY TWO
Breakfast:	Breakfast:
Lunch:	Lunch:
Dinner:	Dinner:
Snacks:	Snacks:

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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 Life Wellness & Chiropractic 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: _____________________________________