Nutrition in Motion, LLC

NRT NEW PATIENT 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 _____

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Office Use Only:

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Nutrition in Motion, LLC
NEW PATIENT INFORMATION FORM

Name: _____ Date._____

HISTORY:

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

_____

List any surgery or operations with approx. 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 _____

Nutrition in Motion, LLC

www.nutrition-in-motion.net 215 272 6774

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

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Nutrition in Motion, LLC 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: -

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SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date _____ Approx Weight _____ Sex: Male O ___ Female O

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes O No O

Blood pressure: Recumbent / Standing Ragland's Test is Positive O

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

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

1 2 3 **GROUP 1**

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

GROUP 3

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

GROUP 3

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

1 2 3

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

GROUP 4

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

GROUP 5

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

GROUP 6

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