

HEALTH UNLIMITED

5570 Powers Center Point

New Patient Information Forms **(1 of 2)**

Name _____ Date _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Mailing/Shipping Address (if different) _____

Home Phone (_____) _____ Work or Cell Phone(_____) _____

Email Address: _____

REFERRED BY: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age _____ Sex: F / M Height _____ Weight _____

Overall Health: (circle one) Excellent / Good / Fair / Poor / Other: _____

Chief Complaints (reason you are here)

Previous Treatments for this
complaint: _____

Current Medications/drugs you are
taking: _____

Are you currently under the care of a physician or other health care professional? (If yes, please
give name and date of last visit) _____

Nutritional Supplements or Vitamins currently taking: _____

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

Cigarettes: _____ Coffee _____ Alcohol _____

Name _____ Date _____

HISTORY:

List any major illnesses (with approx. dates):

List any surgery or operations (with approx. dates):

Past Accidents or Injuries:

.....

Marital Status: S M D W

Name of Spouse: _____

Number of children: _____

Name of Child	Age	Sex	Any physical concerns or conditions?
_____	_____	F / M	_____
_____	_____	F / M	_____
_____	_____	F / M	_____

Any family history of serious illnesses such as cancer, diabetes, heart, etc. (list any)

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 _____

HEALTH UNLIMITED

5570 Powers Center Point CO 80920

PERMISSION & AUTHORIZATION FORM REGARDING

THE USE OF NUTRITION RESPONSE TESTING

Please read before signing:

I specifically authorize the natural health practitioner at Health Unlimited to perform a Nutrition Response Testing health analysis and to develop a natural 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 imbalances 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: _____

Signature: _____

(If minor, signature of parent or guardian is required)

Witness: _____ Date _____

HEALTH UNLIMITED

Cancellation Policy

To ensure that our patients are aware of our policy, we ask you to read the following statement and to verify that you understand by signing below.

24 hour notice for cancellation of an appointment is appreciated. Patients will be billed a **No Show Fee of \$45.00** for their appointment if Dr. Jessica German is not notified **within four hours of the scheduled appointment**. The \$45.00 fee will be billed to the patient and must be paid by their next scheduled appointment or within one month of the missed appointment.

This policy will be enforced without exception

Signature:

Date:

Staff intial: