ALINEA
Natural Health

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NEW CLIENT INTRODUCTION FORM

Please print clearly:

Name _____ Date: _____

Address _____City _____ State: _____ ZIP: _____

Primary 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

Chief complaint (reason you are here): (use separate sheet if more room needed)

_____

_____

Previous treatments for this complaint _____

_____

Other complaints or problems: (use a separate sheet if needed) _____

_____

Current Prescription and/or Over the Counter medications being taken: _____

_____

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 currently taking: _____

Do you smoke? _____ Do you drink coffee? _____ Do you drink alcohol? _____

History

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

_____

List any surgery or operations with approx. dates: _____

Past accidents or injuries: _____

Marital Status: Single / Married / Divorced / Widowed Name of Spouse: _____

Describe Health of Spouse:_____ Number of Children: _____

Name of Child
_____M / F Age: _____ Health Concern if any: _____
_____M / F Age: _____ Health Concern if any: _____
_____M / F Age: _____ Health Concern if 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? _____

Current Health Survey

Your Energy Level: High / Medium / Low **Your Stress Level**: High / Medium / Low

What do you consider as Stressors in your life right now? _____

Any difficulty going to Sleep? _____ How many hours sleep average per night? _____

Typical Daily Food Intake
- Breakfast:
- Lunch:
- Dinner:
- Snacks:

How much Water do you drink daily? _____

Do you also drink (circle all that apply):
Coffee Tea Soda Wine Beer Energy Drinks Meal Replacements

Do you experience digestive discomfort? _____ when?_____ how often? _____

Do you exercise? _____ what do you do?_____ how often?_____

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF

NUTRITIONAL RESONSE TESTING

I specifically authorize the natural health practitioners at Alinea Natural Health, PMA to perform a Nutrition Response Testing health analysis and to develop a natural, complimentary 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 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.

Alinea Natural Health, PMA ***does not diagnose, cure or treat any illness or disease***. Health Coaching provided by Michele Fuller and Alinea Natural Health Staff through Alinea Natural Health, PMA is not intended to, cannot, and should not be expected to substitute for a personal consultation with your own physician.

Understanding of Above and Consent

☐ I have read and agree to the Terms and Conditions listed above

This permission form applies to subsequent visits and consultations.

Print Name: _____

Signature of Client or Guardian: _____ Date: _____