Health Care Chiropractic Centre
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:

Natural Health Improvement Center
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: _____

_____

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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 ☐☐	_____

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 _____

Health Care Chiropractic Centre

215 Atlantic Avenue Suite A Lynbrook, NY 11563 Phone (518) 887-1001 goldspinechiropractic.com

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

PLEASE READ BEFORE SIGNING:

I specifically authorize Dr. Steven B. Goldstein 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 organ responses 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:_____