Nutrition Response Testing®
NEW CLIENT INFORMATION FORM

Please print clearly. Today's Date: _____

Name: _____

Address: _____ Unit/Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Email: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Age: _____ Overall Health: _____

Main issue (reason you're here): _____

Previous treatment(s) for this issues: _____

Other current issues/problems: _____

Current medications/drugs: _____

Current nutritional supplements: _____

Are you currently under the care of a physician or other healthcare professional(s)? _____

If yes, give name(s) and date(s) of last visit(s): _____

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Do you smoke? _____ If yes, how much per day/week? _____

Do you drink coffee? _____ If yes, how much per day/week? _____

Do you drink alcohol? _____ If yes, how much per day/week? _____

Have you had any immunizations in the last few years? _____

If yes, which ones and when? _____

Have you had any organs or body parts removed? _____

If yes, which ones and when? _____

List any major illnesses with approximate dates: _____

List any other surgeries with approximate dates: _____

List past accidents or injuries: _____

Any family history of serious illnesses? (such as cancer, diabetes, heart, etc.)? List here: _____

Any household pets or other animals you/family members are in close contact with? List here: _____

What can we do to make you happier? Any additional information you want me to know? _____

SIGNED: _____ DATED: _____