Application for Nutrition Response Testing

Please complete all required fields marked with *

Name *

First: | Middle: | Last:

Address *

Street Address:

Address Line 2:

City: | State / Province: | ZIP / Postal Code:

Home Phone *

Cell Phone

Office Phone

Referred to our clinic by

Email Address

Enter Email: | Confirm Email:

Occupation *

Employer Name *

Employer Address

Street Address:

Address Line 2:

City: | State / Province: | ZIP / Postal Code:

Height (feet) *

Height (inches) *

Weight * *Weight in pounds*

Age *

Sex *

- ◯ Male
- ◯ Female

Date of Birth *

Month: Day: Year:

Overall Health *

- ◯ Excellent
- ◯ Good
- ◯ Fair

Relationship Status *

- ◯ Married
- ◯ Single
- ◯ Widowed
- ◯ Divorced
- ◯ Separated
- ◯ Partnered

Name of Spouse *

Is the patient a minor? *

- ◯ Yes
- ◯ No

Name of Parent or Legal Guardian *

First: Middle: Last:

Chief complaint (reason you are here) *

Previous treatments for this complaint

Other complaints or problems

Current Medications/Drugs being taken *

List Any Drug Allergies *

Are you currently under the care of a physician or other health care professional? *

- ◯ Yes
- ◯ No

Name of professional *

First: Last:

Date of last visit *

Month: Day: Year:

Nutritional supplements you are taking *

Do you smoke, drink coffee or alcohol?

- ☐ Cigarettes
- ☐ Coffee
- ☐ Alcohol

How much coffee? *

How many cigarettes? *

How much alcohol? *

History

List any major illnesses (with approximate dates)

List any surgery or operations (with approximate dates)

Past accidents or injuries

Name of Child(ren), Age, Sex, and any physical conditions or concerns?

Any family history of serious illnesses? *

- [ ] Cancer
- [ ] Diabetes
- [ ] Heart
- [ ] Other
- [ ] None of the above

Any family history of serious illnesses - Please Explain *

Any household pets or other animals you or family members are in close contact with

What can we do to make you happier?

Additional Information

PLEASE READ BEFORE SIGNING:

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Scheduled appointments that are not kept by the patient with no prior notification of cancellation may be subject to a \$25 charge. Returned checks for insufficient funds may be charged \$30 per incident.

Patient Signature

Instructions

INSTRUCTIONS: Mark the number that applies to you. **If a symptom does not apply, leave it blank.**

Mark either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE - SUPPORT PARASYMPATHETIC *

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

GROUP TWO - SUPPORT SYMPATHETIC *

	N/A	(1) Mild	(2) Moderate	(3) Severe
21 Joint stiffness after arising	○	○	○	○
22 Muscle-leg-toe cramps	○	○	○	○
23 "Butterfly" stomach, cramps	○	○	○	○
24 Eyes or nose watery	○	○	○	○
25 Eyes blink often	○	○	○	○
26 Eyelids swollen, puffy	○	○	○	○
27 Indigestion soon after meals	○	○	○	○
28 Always seem hungry; feels "lightheaded" often	○	○	○	○
29 Digestion rapid	○	○	○	○
30 Vomiting frequent	○	○	○	○
31 Hoarseness frequent	○	○	○	○
32 Breathing irregular	○	○	○	○
33 Pulse slow; feels "irregular"	○	○	○	○
34 Gagging reflex slow	○	○	○	○
35 Difficulty swallowing	○	○	○	○
36 Constipation, diarrhea alternating	○	○	○	○
37 "Slow starter"	○	○	○	○
38 Get "chilled" infrequently	○	○	○	○
39 Perspire easily	○	○	○	○
40 Circulation poor, sensitive to cold	○	○	○	○
41 Subject to colds, asthma, bronchitis	○	○	○	○

GROUP THREE - HYPOGLYCEMIA

	N/A	(1) Mild	(2) Moderate	(3) Severe
42 Eat when nervous	○	○	○	○
43 Excessive appetite	○	○	○	○
44 Hungry between meals	○	○	○	○
45 Irritable before meals	○	○	○	○
46 Get "shaky" if hungry	○	○	○	○
47 Fatigue, eating relieves	○	○	○	○
48 "Lightheaded" if meals delayed	○	○	○	○
49 Heart palpitates if meals missed or delayed	○	○	○	○
50 Afternoon headaches	○	○	○	○
51 Overeating sweets upsets	○	○	○	○
52 Awaken after few hours sleep - hard to get back to sleep	○	○	○	○
53 Crave candy or coffee in afternoons	○	○	○	○
54 Moods of depression - "blues" or melancholy	○	○	○	○
55 Abnormal craving for sweets or snacks	○	○	○	○

GROUP FOUR - CARDIOVASCULAR *

	N/A	(1) Mild	(2) Moderate	(3) Severe
56 Hands and feet go to sleep easily, numbness	○	○	○	○
57 Sigh frequently, "air hunger"	○	○	○	○
58 Aware of "breathing heavily"	○	○	○	○
59 High altitude discomfort	○	○	○	○
60 Opens windows in closed room	○	○	○	○
61 Susceptible to colds and fevers	○	○	○	○
62 Afternoon "yawner"	○	○	○	○
63 Get "drowsy" often	○	○	○	○
64 Swollen ankles worse at night	○	○	○	○
65 Muscle cramps, worse during exercise; get "charley horses"	○	○	○	○
66 Shortness of breath on exertion	○	○	○	○
67 Dull pain in chest or radiating into left arm, worse on exertion	○	○	○	○
68 Bruise easily, "black and blue" spots	○	○	○	○
69 Tendency to anemia	○	○	○	○
70 "Nose bleeds" frequent	○	○	○	○
71 Noises in head, or "ringing in ears"	○	○	○	○
72 Tension under the breastbone, or feeling of "tightness", worse on exertion	○	○	○	○

GROUP FIVE - LIVER, GALLBLADDER, INTESTINES *

	N/A	(1) Mild	(2) Moderate	(3) Severe
73 Dizziness	○	○	○	○
74 Dry skin	○	○	○	○
75 Burning feet	○	○	○	○
76 Blurred vision	○	○	○	○
77 Itching skin and feet	○	○	○	○
78 Excessive falling hair	○	○	○	○
79 Frequent skin rashes	○	○	○	○
80 Bitter, metallic taste in mouth in mornings	○	○	○	○
81 Bowel movements painful or difficult	○	○	○	○
82 Worrier, feels insecure	○	○	○	○
83 Feeling queasy; headache over eyes	○	○	○	○
84 Greasy foods upset	○	○	○	○
85 Stools light-colored	○	○	○	○
86 Skin peels on foot soles	○	○	○	○
87 Pain between shoulder blades	○	○	○	○
88 Use laxatives	○	○	○	○
89 Stools alternate from soft to watery	○	○	○	○
90 History of gallbladder attacks or gallstones	○	○	○	○
91 Sneezing attacks	○	○	○	○
92 Dreaming, nightmare type bad dreams	○	○	○	○
93 Bad breath (halitosis)	○	○	○	○
94 Milk products cause distress	○	○	○	○
95 Sensitive to hot weather	○	○	○	○
96 Burning of itching anus	○	○	○	○
97 Crave sweets	○	○	○	○

GROUP SIX - DIGESTION OF PROTEIN *

	N/A	(1) Mild	(2) Moderate	(3) Severe
98 Loss of taste for meat	○	○	○	○
99 Lower bowel gas several hours after eating	○	○	○	○
100 Burning stomach sensations, eating relieves	○	○	○	○
101 Coated tongue	○	○	○	○
102 Pass large amounts of foul-smelling gas	○	○	○	○
103 Indigestion ½ - 1 hour after eating; may be up to 3-4 hours	○	○	○	○
104 Mucous colitis or "irritable bowel"	○	○	○	○
105 Gas shortly after eating	○	○	○	○
106 Stomach "bloating" after eating	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (A) Hyperthyroid *

	N/A	(1) Mild	(2) Moderate	(3) Severe
107 Insomnia	○	○	○	○
108 Nervousness	○	○	○	○
109 Can't gain weight	○	○	○	○
110 Intolerance to heat	○	○	○	○
111 Highly emotional	○	○	○	○
112 Flush easily	○	○	○	○
113 Night sweats	○	○	○	○
114 Thin, moist skin	○	○	○	○
115 Inward trembling	○	○	○	○
116 Heart palpitates	○	○	○	○
117 Increased appetite without weight gain	○	○	○	○
118 Pulse fast at rest	○	○	○	○
119 Eyelids and face twitch	○	○	○	○
120 Irritable and restless	○	○	○	○
121 Can't work under pressure	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (B) Hypothyroid *

	N/A	(1) Mild	(2) Moderate	(3) Severe
122 Increase in weight	○	○	○	○
123 Decrease in appetite	○	○	○	○
124 Fatigue easily	○	○	○	○
125 Ringing in ears	○	○	○	○
126 Sleepy during day	○	○	○	○
127 Sensitive to cold	○	○	○	○
128 Dry or scaly skin	○	○	○	○
129 Constipation	○	○	○	○
130 Mental sluggishness	○	○	○	○
131 Hair coarse, falls out	○	○	○	○
132 Headaches upon arising wear off during day	○	○	○	○
133 Slow pulse, below 65	○	○	○	○
134 Frequency of urination	○	○	○	○
135 Impaired hearing	○	○	○	○
136 Reduced initiative	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (C) Hyper-Pit *

	N/A	(1) Mild	(2) Moderate	(3) Severe
137 Failing memory	○	○	○	○
138 Low blood pressure	○	○	○	○
139 Increased sex drive	○	○	○	○
140 Headaches, "splitting or rendering" type	○	○	○	○
141 Decreased sugar tolerance	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (D) Hypo-Pit *

	N/A	(1) Mild	(2) Moderate	(3) Severe
142 Abnormal thirst	○	○	○	○
143 Bloating of abdomen	○	○	○	○
144 Weight gain around hips or waist	○	○	○	○
145 Sex drive reduced or lacking	○	○	○	○
146 Tendency to ulcers, colitis	○	○	○	○
147 Increased sugar tolerance	○	○	○	○
148 Women: menstrual disorders	○	○	○	○
149 Young girls: lack of menstrual function	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (E) Hyper Andrenals *

	N/A	(1) Mild	(2) Moderate	(3) Severe
150 Dizziness	○	○	○	○
151 Headaches	○	○	○	○
152 Hot flashes	○	○	○	○
153 Increased blood pressure	○	○	○	○
154 Hair growth on face of body (female)	○	○	○	○
155 Sugar in urine (not diabetes)	○	○	○	○
156 Masculine tendencies (female)	○	○	○	○

GROUP SEVEN - ENDOCRINE SYSTEM, HPA AXIS: (F) Hypo Andrenals *

	N/A	(1) Mild	(2) Moderate	(3) Severe
157 Weakness, dizziness	○	○	○	○
158 Chronic fatigue	○	○	○	○
159 Low blood pressure	○	○	○	○
160 Nails, weak, ridged	○	○	○	○
161 Tendency to hives	○	○	○	○
162 Arthritic tendencies	○	○	○	○
163 Perspiration increase	○	○	○	○
164 Bowel disorders	○	○	○	○
165 Poor circulation	○	○	○	○
166 Swollen ankles	○	○	○	○
167 Crave salt	○	○	○	○
168 Brown spots or bronzing of skin	○	○	○	○
169 Allergies - tendency to asthma	○	○	○	○
170 Weakness after colds, influenza	○	○	○	○
171 Exhaustion - muscular and nervous	○	○	○	○
172 Respiratory disorders	○	○	○	○

GROUP EIGHT *

	N/A	(1) Mild	(2) Moderate	(3) Severe
173 Apprehension	○	○	○	○
174 Irritability	○	○	○	○
175 Morbid fears	○	○	○	○
176 Never seems to get well	○	○	○	○
177 Forgetfulness	○	○	○	○
178 Indigestion	○	○	○	○
179 Poor appetite	○	○	○	○
180 Craving for sweets	○	○	○	○
181 Muscular soreness	○	○	○	○
182 Depression; feelings of dread	○	○	○	○
183 Noise sensitivity	○	○	○	○
184 Acoustic hallucinations	○	○	○	○
185 Tendency to cry without reason	○	○	○	○
186 Hair is coarse and/or thinning	○	○	○	○
187 Weakness	○	○	○	○
188 Fatigue	○	○	○	○
189 Skin sensitive to touch	○	○	○	○
190 Tendency toward hives	○	○	○	○
191 Nervousness	○	○	○	○
192 Headache	○	○	○	○
193 Insomnia	○	○	○	○
194 Anxiety	○	○	○	○
195 Anorexia	○	○	○	○
196 Inability to concentrate; confusion	○	○	○	○
197 Frequent stuffy nose; sinus infections	○	○	○	○
198 Allergy to some foods	○	○	○	○
199 Loose joints	○	○	○	○

FEMALE ONLY *

	N/A	(1) Mild	(2) Moderate	(3) Severe
200 Very easily fatigued	○	○	○	○
201 Premenstrual tension	○	○	○	○
202 Painful menses	○	○	○	○
203 Depressed feelings before menstruation	○	○	○	○
204 Menstruation excessive and prolonged	○	○	○	○
205 Painful breasts	○	○	○	○
206 Menstruate too frequently	○	○	○	○
207 Vaginal discharge	○	○	○	○
208 Hysterectomy/ovaries removed	○	○	○	○
209 Menopausal hot flashes	○	○	○	○
210 Menses scanty or missed	○	○	○	○
211 Acne, worse at menses	○	○	○	○
212 Depression of long standing	○	○	○	○

MALE ONLY *

	N/A	(1) Mild	(2) Moderate	(3) Severe
213 Prostate trouble	○	○	○	○
214 Urination difficult or dribbling	○	○	○	○
215 Night urination frequent	○	○	○	○
216 Depression	○	○	○	○
217 Pain on inside of legs or heels	○	○	○	○
218 Feeling of incomplete bowel evacuation	○	○	○	○
219 Lack of energy	○	○	○	○
220 Migrating aches and pains	○	○	○	○
221 Tire too easily	○	○	○	○
222 Avoids activity	○	○	○	○
223 Leg nervousness at night	○	○	○	○
224 Diminished sex drive	○	○	○	○

Additional Information

IMPORTANT

Physical complaint 1

Physical complaint 2

Physical complaint 3

Physical complaint 4

Physical complaint 5

Authorization Statement

Chi Rho Corrective Spinal Care and Wellness

PERMISSION & AUTHORIZATION FORM

REGARDING THE USE OF NUTRITION RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Chi Rho Corrective 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 in 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.

Signature of patient

Signature of parent or guardian only

Privacy & Consent Statement

Chi Rho Corrective Spinal Care and Wellness

Patient Consent for Use and Disclosure Of Protected Health Information

PLEASE READ BEFORE SIGNING:

I hereby give my consent for Chi Rho Corrective, P.A. (hereinafter referred to as "CRC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

CRC's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of this Notice is available upon request to Dr. Joshua Witter, our Privacy Officers, or any other CRC staff member.

CRC reserves the right to revise its Notice of Privacy Practices at any time and agrees to provide me a revised copy upon my request to CRC.

With this consent, the CRC may call (or text message) my home or other designated phone number on file and leave a message on voice mail or in person in reference to any items that assist CRC in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, CRC may mail to my home or other designated location on file any items that assist CRC in carrying out TPO, such as patient statements.

With this consent, CRC may e-mail to my home or other designated location on file any items that assist CRC in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that CRC restrict how it uses or discloses my PHI to carry out TPO. However, CRC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CRC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that CRC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, CRC may decline to provide treatment to me as permitted by Section 164.506 of the Code of Federal Regulations.

Signature of patient

Signature of parent or guardian only

Consent

☐ I have been given and am in receipt of CRC's Notice of Privacy Practices.

Consent

☐ I do not wish to receive a copy of CRC's Notice of Privacy Practices.

(please initial)

(please initial)