

Welcome to Bridge To Natural Wellness.

Below are Client Information Forms for you to print, complete and bring with you to your first appointment. These include the New Patient Information Form pages 1 & 2 and the Permission & Authorization Form. Please advise us if you can't access the forms.

Be sure you bring the following to your appointment:

- Client Information Forms
- Prescription Medications (actual bottles of meds, not a list of meds)
- Supplements, vitamins, protein powders, etc. that you are currently taking (actual products)

What you can expect? Your first appointment will take approximately 1 ½ hours. This allows for the evaluation, testing and any questions or concerns you may have. Nutrition Response Testing relies on the flow of your body's energy. To insure the best possible results we recommend that you not wear black clothing for your appointment.

Because many of our clients are dealing with chemical or respiratory challenges, we asked that all of our clients refrain from using scented products (perfume, after shave, body sprays, etc.) when coming for an appointment.

We look forward to meeting with you. We have also enclosed directions to make it easier for you to find us. If you have any questions, please feel free to call me at 603-493-0490.

Sincerely,  
Denise McMahon  
Master Clinician  
1100 Hooksett Rd. Suite #102,  
Hooksett, NH 03106  
(603) 493-0490.

#### **Directions**

**Take US Rte 93 to exit 9N which will bring you to a set of traffic lights on Rte 3, Hooksett Rd. As you approach the traffic lights, get in the center lane.**

**Go through the set of lights and, at the end of the divider, turn left into Community Plaza. Continue toward the far end of the parking lot.**

**We are located in the Hooksett Family Chiropractic office which is the next to the last unit.**

# NEW PATIENT INFORMATION FORM

Page 1 of 2

*Please print clearly:*

Date: \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI: \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_

**REFERRED BY:**  Internet/Website  Super Pages  Yellow Pages

Family/Friend Name: \_\_\_\_\_

Other: \_\_\_\_\_

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):

Are you a vegetarian/vegan? \_\_\_\_\_

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:

### NEW PATIENT INFORMATION FORM

Page 2 of 2

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

**HISTORY:**

List any major illnesses (with approx. dates): \_\_\_\_\_  
\_\_\_\_\_

List any surgery or operations with approx. date: \_\_\_\_\_  
\_\_\_\_\_

Past Accidents or injuries: \_\_\_\_\_  
\_\_\_\_\_

=====  
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	_____
_____	_____	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 \_\_\_\_\_

**PERMISSION & AUTHORIZATION FORM  
REGARDING THE USE OF NUTRITION RESPONSE TESTING™**

**PLEASE READ BEFORE SIGNING:**

I specifically authorize the natural health practitioner 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 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: \_\_\_\_\_  
First Name, Middle Initial, Last Name

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signed: \_\_\_\_\_

(If minor, signature of parent or guardian required)

Witness: \_\_\_\_\_