

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? The cost of the evaluation is \$100.00. Your first appointment will take approximately 1 ½ - 2 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 ask that all of our clients **please 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 McMahan
Master Clinician
1802 Elm St Suite #3
Manchester, NH 03104
(603) 493-0490.

Directions

- **Take US Rte 93 to exit 9S and merge onto Rte 3 South, Hooksett Rd.**
- **Continue on Rte 3 South to Webster St (continuation of Rte 3 South)**
- **Right on Webster St to Elm St**
- **Left on Elm St to West North St (one tenth of a mile)**
- **Right on West North St to the first driveway on the right**
- **Right into the driveway – our building will be on the left**

NEW PATIENT INFORMATION FORM

Page 1 of 2

Please print clearly:

Appointment Date: _____

Name: Last _____ First _____ MI: _____

Address _____ Apt. # _____

City _____ State _____ ZIP _____

Mailing Address (if different) _____

Home Phone (____) ____ - _____ Work / Cell Phone (____) ____ - _____

Please indicate phone type

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? _____ (Please circle which)

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

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 _____

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: _____