Welcome to Bridge To Natural Wellness.

Below are Client Information Forms for you to **complete and submit to us either electronically or by mail at your earliest convenience**. These include the New Patient Information Form pages 1 & 2 and the Permission & Authorization Form. Please advise us if you can't access or print the forms.

Be sure you bring the following to your appointment:

- 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 your initial evaluation is $180.00. Follow-up visits are $50.00. The evaluation will take approximately 1 ½ to 2 hours. This allows for the explanation of the process, 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 **DO NOT WEAR SCENTED PRODUCTS** (perfume, after shave, body sprays, essential oils, etc.) when coming for an appointment.

If for some reason you cannot keep your appointment, please give us two business days' notice if at all possible. If you fail to notify us at least twenty hours prior to your appointment, you will be responsible for the evaluation fee.

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 us at 603-232-6506.

Sincerely,
Denise McMahon
Master Clinician
1802 Elm St Suite 3
Manchester NH 03104
(603) 232-6506
FAX: 603-606-1821

Directions

Via Rte 93

- **Take US Rte 93 (if coming from the east on Rte 101, go north on 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 W North St (one tenth of a mile)**
- **Right on W North St to the first driveway on the right**
- **Right into the driveway – our building will be on the left**

From the south on Rte 3

- **Take US Rte 3 North (becomes Everett Tpke in NH)**
- **Continue straight onto Rte 293 North (AFTER THE TOLL BOTH)**
- **IMPORTANT – do not take exit 6 until AFTER you have gone through the toll booth)**
- **Take Exit 6 ramp and stay to the right (La Quinta Hotel will be on your right)**
- **When crossing the bridge move to the left lane**
- **LEFT at the traffic light (Elm St / Rte 3 North)**
- **LEFT on W. North St (first street on the left)**
- **RIGHT into the first driveway**
- **Our building will on the left**

PLEASE – DO NOT WEAR SCENTED PRODUCTS

(perfume, after shave, body sprays, essential oils, etc.)

NEW PATIENT INFORMATION FORM

Please print clearly: Appointment Date:_____

Name: Last_____ First _____MI: _____
Address _____ Apt. #_____
City _____ State_____ ZIP_____
Mailing Address (if different) _____
_____
Home Phone (____) ____-_____ Work / Cell Phone (____) ____-_____
Please circle 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:

1802 Elm St Suite 3 **(603) 232-6506**
Manchester, NH 03104 **email: rick@btnw.comcastbiz.net** **www.btnwhc.com**

NEW PATIENT INFORMATION FORM

Name: Last_____ First _____ MI _____

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	_____
_____	____	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 _____

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Manchester, NH 03104 **email: rick@btnw.comcastbiz.net** **www.btnwhc.com**

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:_____

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