NRT New Patient Information Form

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit): _____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (If yes, indicate how much.)
Cigarettes _____ Coffee _____ Alcohol _____

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: _____

Leverenz Family Chiropractic

2915 Lapeer Ave.
Port Huron, MI 48060
(810) 985-0084

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NRT New Patient Information Form

Please print clearly:
Name_____ Date _____

Address _____ Apt. #_____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Text Message Appt. Reminder □Yes □ No Cell Phone Carrier Name _____

e-mail address _____

REFERRED BY: _____

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 is 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) _____

_____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

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Fee Schedule for your Convenience:

Follow-up office calls: $40.00

Nutritional supplements are extra, based on an individual program. The normal time available for a follow up visit is 10 minutes. Realize that not all questions can be answered in a visit. The purpose of follow-up care is to incrementally increase ones knowledge of their health condition and the natural methods available to improve on it. A typical follow-up office call consists of:

1. Their subjective response to the health improvement program. (How are you feeling?)
2. Retesting of their active reflexes to determine their response to nutritional supplementation.
3. Retesting to discover if any new reflexes are present.
4. Answering of focused questions that are relevant to their situation.

Pre-payment Plans:

If you are fully committed to restoring your health and wish to prepay for office calls we offer 2 savings plans.

6 visits in advance $210 (for a savings of $30.00)
12 visits in advance $390 (for a savings of $90.00)

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Permission and Authorization for the use of Nutritional Response Testing

Please read before signing.

I specifically authorize the doctors and natural health care practitioners at Leverenz Family Chiropractic to perform Nutritional Response Testing analysis and develop a natural, complementary health improvement program for me which may include nutritional supplements, dietary guidelines, and mild exercise, in order to assist me in improving my health, and not for the treatment or "cure" of any disease.

I understand chiropractic and nutritional testing are safe, natural, noninvasive methods of analyzing the body's nutritional and physical needs, and that deficiencies or imbalances in these areas may cause or contribute to various health problems.

No promise or guarantee has been made regarding the results of Nutritional Response Testing or any nutritional supplement or dietary program. I understand that NRT is a means by which the body's natural reflexes can be used to determine possible imbalances, and that by correcting these imbalances, the body may achieve greater overall health.

I hereby authorize the doctor to handle my condition as he/she deems appropriate through the use of Nutritional Response Testing analysis. Patients who have diseases will receive nutritional support for their general health and the correction of vertebral subluxations. The doctors of Leverenz Family Chiropractic are doctors of chiropractic and do not practice medicine or diagnose medical conditions. The doctors shall not be held liable for any disease condition or for any preexisting medically diagnosed condition.

I understand Nutritional Response Testing is not covered by health insurance and therefore payment is the responsibility of the patient and due at the time of treatment.

I have read and understand the above statements. This permission for Nutritional Response Testing applies to todays and all subsequent office visits.

Name: _____ Signature: _____
(Please Print) (If under 18 years old, signature of parent or legal guardian)

Date: _____ Witness Signature: _____