Nutritional Wellness Initiative, LLC

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Nutritional Wellness Initiative, LLC 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

Print Name _____

Phone # _____

Email _____

Address _____

City _____ State _____ Zip _____

Date _____

Sign _____

(If minor, signature of parent or guardian required)

Nutritional Wellness Initiative, LLC

10607 Deerbrook Drive, Knoxville, TN 37922
Phone (865) 282-6217

Name _____
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):

Previous Treatments for this complaint:

Other complaints or problems:

Current medications/drugs/nutritional supplements being taken:

Are you currently under the care of a physician or other health care professionals? If so, please give name and date of last visit: _____
Do you smoke, drink coffee or alcohol? If so, please indicate how much.
Cigarettes _____ Coffee _____ Alcohol _____
List any major illnesses, surgery or operations with the approximate dates:

Past accidents or injuries: _____
Marital Status: S M D W Name of Spouse _____ # of Children _____
Describe health of Spouse

Name of Child	Age	Sex	Any Physical conditions or concerns?

Any family history of serious illnesses? (circle those which apply)
Cancer Diabetes Heart Other _____
List household pets or other animals you or family members are in close contact with