The Spring
Center for Natural Medicine

2416 S. Lamar Blvd., Suite B, Austin, TX 78704 www.thespringatx@gmail.com 512-445-7373

Please remember to bring ALL your completed paperwork with you.

If you do not bring your paperwork in or if your paperwork is not FULLY completed, we will not be able to see you.

New Health Evaluation

Your New Health Evaluation will last 45 minutes to 1 hour and will include a thorough non-invasive history and exam, a Heart Rate Variability Test and may include a neurological and kinesiology examination using the Nutrition Response Testing.

We will use these evaluations to determine if your case is a good fit for us and you use this time to decide if we are a good fit for you. If we decide we are a good fit for each other, we will structure a program for you based on our findings and present this to you at your second visit.

Report of Findings

The Report of Findings visit will last 30 minutes. We discuss all our findings and our plan of action moving forward. We will typically schedule this visit the same day or within 2 days of your first visit. We will present you with your Report of Findings prior to the visit, so that you can read through it and prepare any questions you may have in advance. We will also determine if any lab testing is warranted at this stage.

If you agree with our treatment plan and choose to follow our suggested plan we will start treatment on this day using Nutritional Response Testing and any other modality needed on the day.

Subsequent visits

These visits typically last 15 minutes and treatment modalities will be determined on the day based on your specific needs. Longer appointments may be required to go over test results but this will be discussed in advance.

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PERMISSION AND AUTHORIZATION FORM
REGARDING THE USE OF
NUTRITION RESPONSE TESTING™

Please read before signing:

I specifically authorize the natural health practitioners at The Spring, Center for Natural Medicine 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,scar treatment 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 imbalances in these areas could cause or contribute to various health problems.

I understand Nutrition Response Testing is not a method for diagnosing or treating any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

I understand that I am not seeing a physician and that no promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary recommendations.

Cancellation Policy No fee is charged if a 24 hour notice is given for a cancellation. Late cancellations or 'no shows' will be charged .

I have read and understand the foregoing.
This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City, State, ZIP:_____

Phone: _____

Signature: _____

Signature parent/guardian if minor: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in our office and your rights concerning those records. Before we are able to start any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available at the front desk before signing this consent.

1. The patient understands and agrees to allow the office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of the records for care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those that do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the practitioner has the right to refuse to give care

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Signature of patient Date Name of Patient

_____

Signature of parent if minor Date Name of Patient

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Today's Date:_____ Referred by:_____

Name:_____ M ☐ F ☐ Birthdate:_____Age:_____

Mailing Address: _____

City:_____State:_____Zip:_____Occupation: _____

Daytime phone:_____ Evening phone:_____

Email address: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Spouse's Name: _____

Emergency Contact- Name_____ Phone: _____

Chief complaints. Please tell us the main reason you are here- _____

_____

_____

Secondary Complaints. Please tell us about other health concerns you may have-_____

_____

_____

Previous Treatments for these Complaints - _____

_____

_____

Are you currently under the care of a physician or health care professional? If yes, please give name and date of last visit- _____

_____

Major Illness- Please list all major illness and approximate dates- _____

_____

_____

Surgeries - Please list all surgeries and approximate dates- _____

_____

_____

Injuries- Please list all injuries and traumas and approximate dates- _____

_____

_____

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Current Medication(drugs) and dosage (use separate sheet if needed)- _____

_____

_____

Current nutritional supplements and dosage (use separate sheet if needed)- _____

_____

_____

Please list any allergies (including food)- _____

_____

Any family history of serious illnesses (circle all that applies) Cancer/ Diabetes/ Heart disease/Other -_____

Describe health of spouse/partner- _____

No. of Children(if any):_____

Name of child	Age	Sex	Health or health concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Weight:_____ Height:_____

Do you drink coffee? Y☐ N☐ How much per day? _____

Do you drink alcohol? Y☐ N☐ Type and quantity- _____

Do you smoke? Y☐ N☐ Type and quantity- _____

Do you exercise? Y☐ N☐ Type and duration- _____

Do you have any trouble with sleep? Y☐ N☐ Please explain-_____

_____

Do you have pets? Y☐ N☐ What Kind and how many- _____

WOMEN ONLY

Are you pregnant? Y☐ N☐ Are you trying to conceive? Y☐ N☐ Are you nursing? Y☐ N☐

Do you have regular monthly periods? _____

Circle any of the following symptoms you experience associated with your period:
Cramping bloating moody heavy bleeding back pain headaches clots

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Dietary Intake for 2 days before appointment

Day 1	**Day 2**
Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**
Water and other liquids:	**Water and other liquids:**

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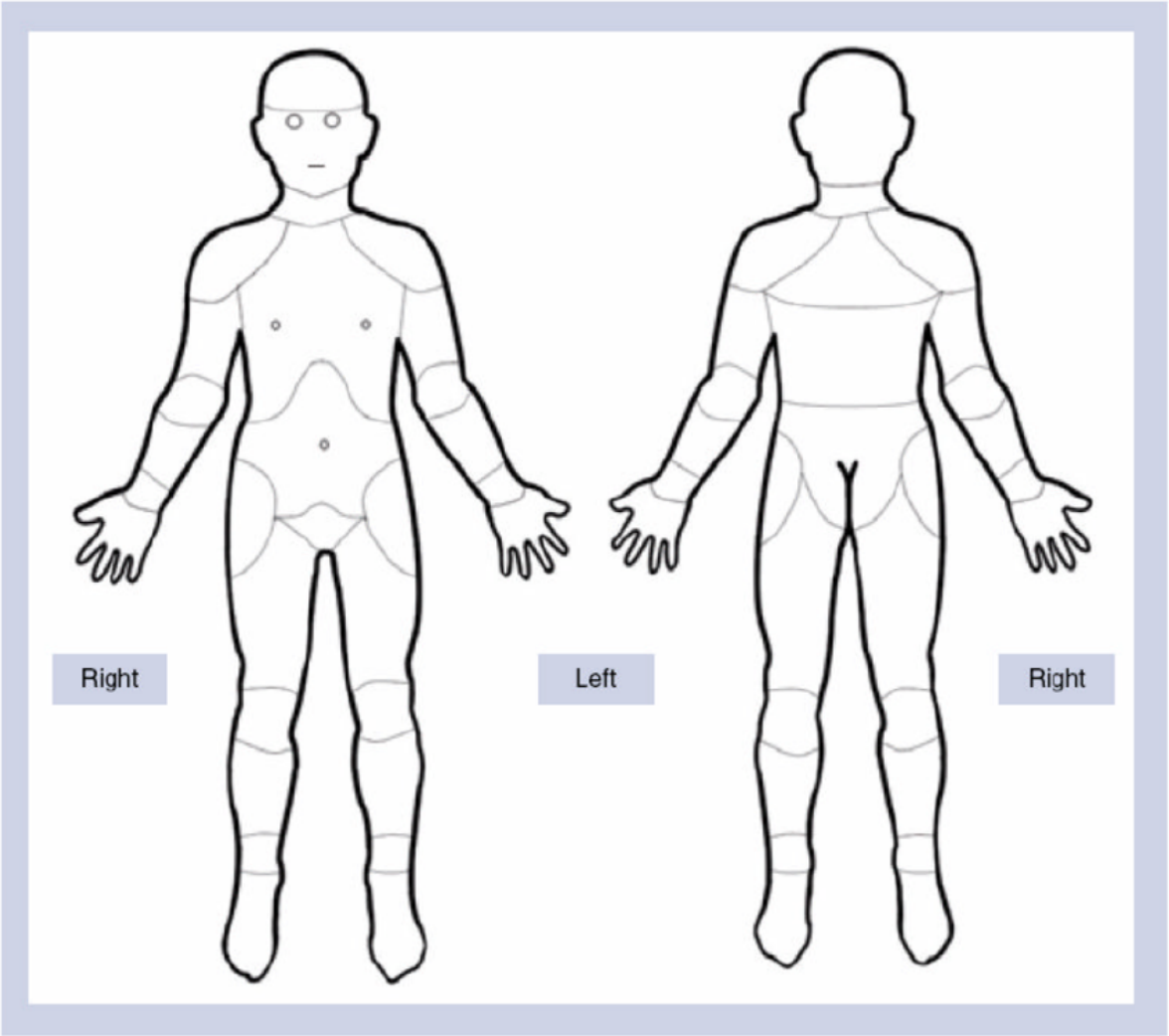

Scars, Surgeries, Piercings, Tattoos and Metal Implants

On the diagram above please indicate where you have any scars, piercings, tattoos and metal implants.

Don't forget about C-sections, episiotomies, cosmetic surgery, vasectomies, laparoscopic surgeries, metal pins, trauma scars, joint replacements and vaccination scars

Office use only

Scars ☐
Piercings ☐
Tattoos ☐
Surgery ☐
Trauma ☐
Implants ☐

Dental Chart

On the chart below please indicate the following:

- Silver fillings
- Composite or porcelain fillings
- Gold Fillings
- Crowns
- Root canals
- Veneers
- Bridges
- Dentures
- Extracted teeth (don't forget about the wisdom teeth)