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.

New Client Evaluation-Child

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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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Client Health Information Consent Form

We want you to know how your Client Health Information (**CHI**) 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 CHI we encourage you to read the HIPAA NOTICE that is available at the front desk before signing this consent.

1. The client understands and agrees to allow the office to use their CHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The client has the right to examine and obtain a copy of his or her own records at any time and request corrections. The client may request to know what disclosures have been made and submit in writing any further restrictions on the use of their CHI. Our office is not obligated to agree to those restrictions.
3. A client's written consent need only be obtained one time for all subsequent care given the client in this office.
4. The client 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 client 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. Client have the right to file a formal complaint with our privacy official about any violations of these policies and procedures.
7. If the client 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 Client Health Information will be used and I agree to these policies and procedures.

_____

Signature of client Date Name of Client

_____

Signature of parent if minor Date Name of Client

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Today's Date:_____ Referred by:_____

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

Parent information: Name:_____ Daytime phone:_____

Email address: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____

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- _____
_____
_____

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

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

_____

_____

Please list any allergies (including food)- _____

_____

Weight:_____ Height:_____

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

Do you have any problems with focus and attention? Y☐ N☐ _____

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

Did you get vaccinated? Y☐ N☐ _____

Are you physically active? Y☐ N☐ _____

Do you go to school? Y☐ N☐ Home school☐ Public school☐ Private school☐

How much screen time do you have per day.(incl cell phone, tablet and computers)_____

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

What can we do to make you happier? _____

_____

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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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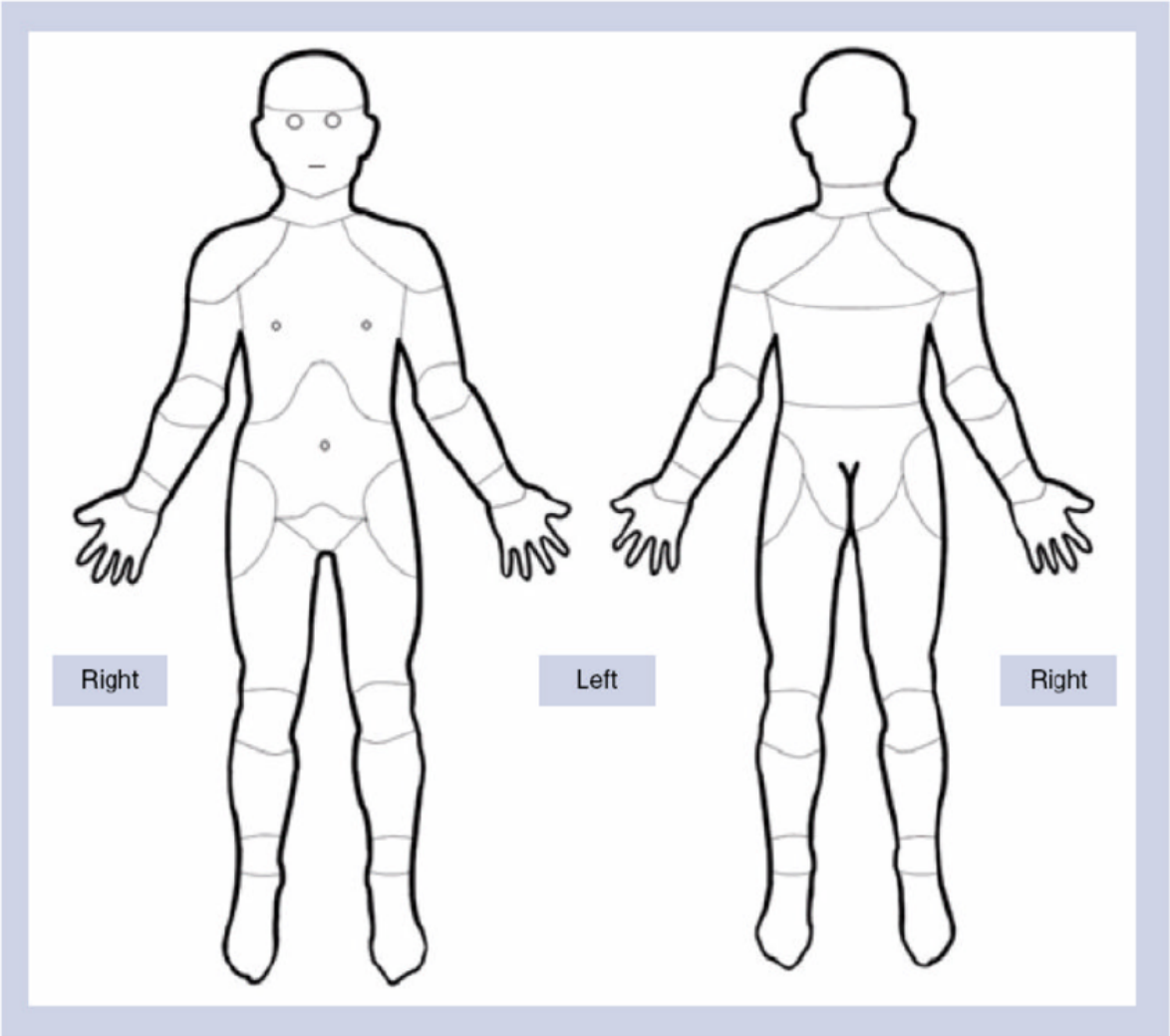


Scars, Surgeries, Piercings, Tattoos and Metal Implants

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

Don't forget about laparoscopic surgeries, metal pins, trauma scars, joint replacements and vaccination scars

Office use only

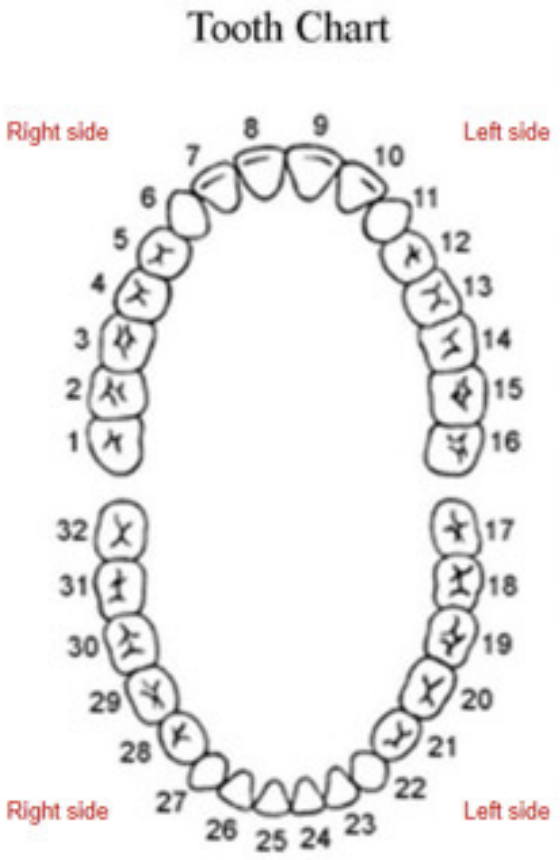
Scars ☐
Piercings ☐
Tattoos ☐

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)



SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male Female

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes No

Blood pressure: Recumbent ___/___ Standing ___/___ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma
	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____