



The body **speaks**  
...we **listen.**

*What does yours  
have to say?*

Organic Approach Chiropractic LLC  
39083 Garfield Road  
Clinton Township, MI 48038  
586-421-4356

**NEW PATIENT INFORMATION FORM**

Page 1 of 2

Please print clearly:

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt.# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Shipping Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Email 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 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):

Nutritional supplements you are taking: \_\_\_\_\_

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes \_\_\_\_\_ Coffee \_\_\_\_\_ Alcohol \_\_\_\_\_

Allergies \_\_\_\_\_

=====



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Page 2 of 2

Name: \_\_\_\_\_ Date \_\_\_\_\_

**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 \_\_\_\_\_

Additional Dr/Staff Notes:



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**PERMISSION & AUTHORIZATION REGARDING THE USE OF NUTRITION  
RESPONSE TESTING AT ORGANIC APPROACH CHIROPRACTIC LLC**

**PLEASE READ BEFORE SIGNING:**

I specifically authorize the natural health practitioner(s) at the Organic Approach Chiropractic LLC to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me. This may include dietary guidelines, nutritional supplements, etc... in order to assist me in improving my health. **I understand this is not for treatment or "cure" of any disease, sickness or illness.**

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 or conditions.

**I understand the 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/treated here at Organic Approach Chiropractic LLC.**

No promise or guarantee has been made regarding the result 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 and employed as an aid to determining possible nutritional imbalances, so that a safe natural program can be developed for the purpose of bringing about a more optimum state of health & wellbeing from within.

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

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Signed: \_\_\_\_\_ (If minor, signature of parent or guardian required)

Witness: \_\_\_\_\_