Life Enhancing Wellness Centers, LLC
Ruckersville, Virginia
434-481-2012 *www.LifeEnhancingWellnessCenters.com*

Print Full Name of patient _____

If minor Name of Legal Guardian_____

If married spouse's name _____ Children: Yes : How many _____

Address _____City _____State _____Zip_____

Cell Phone _____ Home Phone _____ Work Phone _____

Patient Email_____

Date of Birth _____ Patient's Marital Status: Single Married Separated Divorced Widowed

Social security # _____

Who referred you to our office? _____

Employer/School attending if student _____

Employer/school address _____

What kind of daily activities do you do at work and/or home? (P**lease circle:** standing for more than 1 hour, driving more than an hour at a time, loading/unloading vehicles, stockyard or warehouse work, drive heavy machinery, frequent bending, landscaping, farm work, child care, housework, use laptop/tablet on the sofa/chair regularly, desk work, riding lawn mower/tractor, yard work, use computer at work for more than an hour at a time, other _____.

Please describe your average day _____

**We have PRE-PAYMENT plans for cost savings so please ask about them.

How will you be paying for today's charges? Cash Check Major Credit Card

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Name of nearest living relative not living with you _____relation? _____

phone # _____ (this is for emergency contact purposes)

We will provide a receipt for you to submit to your insurance if would like as we do not file insurance for nutritional services. Payment in full is due at the time of service.

** I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service. _____ (initial here)

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional/dietary advice and Nutritional Response Testing are not intended as a diagnostic procedure or primary treatment or therapy for any disease or particular bodily symptom. We do not diagnose/treat any specific disease with our nutritional services. Nutritional Response Testing, dietary

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counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutritional supplements are provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. No promise or guarantee of result is made regarding the results of Nutritional Response Testing and/or any laboratory work recommended by the doctor. Nutritional Response Testing is a means by which the body's natural organ responses can be used as an aid to determine the possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing the about a more optimum state of health. The advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

Patient's Signature_____ Date _____
If under 18 years of age, parent or guardian's signature _____

New Nutrition Patient Information

Overall health (circle one) Good Fair Poor Other_____
What is your main complaint that you would like help with? _____
Other secondary Problems _____
Previous treatments for these problems _____
Surgeries (C-sections, episiotomy) _____

Current Medications:
Drug mg How many per day? What is it for?

_____
_____
_____
_____
_____
_____
Current supplements: _____
_____
Are you under the care of any other healthcare provider for this or anything else? Y N
If so name and address, phone _____
_____

Circle Yes/No **Do you smoke?** Yes, If so how many per day _____ No

Do you drink coffee? Yes: how many cups/day _____ No

Sodas, diet or regular # oz/day _____ No

Fruit juice, sports drink, Energy Drinks? #/day/week _____ No

Drink alcohol # of drinks/week _____ Not really _____

Do you eat sugary treats regularly? Yes: Days per week _____ once in a while or Not really

Family History of Illnesses: _____