This form is designed to fill out online just as you would a web form. Simply click your mouse over the lines to be filled out, & complete them by typing in your information. By holding your mouse over any field, you can view a short description of what to enter in that field. Use the tab key or your mouse to navigate fields. When done, click the print button at the bottom of the form, sign where highlighted & bring with you to Vernal Chiropractic Clinic on your first visit. You may also print the form without filling it out online so that you may fill it out manually if you wish to do so. These instructions (& everything in yellow) will not be printed.

VERNAL CHIROPRACTIC CLINIC'S NUTRITION RESPONSE TESTING
NEW CLIENT INFORMATION FORM

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Shipping Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

E-mail Address _____

Referred By _____

Occupation _____ Employer _____

Date Of Birth _____ Age _____ Sex Select _____ Height Select Select _____ Weight _____

Overall Health _____

Chief Complaint (reason you are here) _____

Previous Treatments For This Complaint _____

Current Medication/Drugs Being Taken _____

Are You Currently Under The Care Of A Physician Or Other Health Care Professional Select _____

If Yes, Please List Name And Date Of Last Visit _____

Nutritional Supplements You Are Currently Taking _____

Do You Smoke, Drink Coffee Or Alcohol Select _____ If Yes, Please List How Much _____ Cigarettes _____ Coffee _____ Alcohol _____

HISTORY

List Any Major Illnesses With Approximate Dates

List Any Surgeries Or Operations With Approximate Dates

List Past Accidents Or Injuries With Approximate Dates

Select — Marital Status

Name Of Spouse

Select — Number Of Children, If Any

Child's Name	Age	Sex	Any Physical Conditions Or Concerns
		- -	
		- -	
		- -	

Any Family History Of Serious Illnesses

Any Household Pets Or Other Animals You Or Your Family Members Are In Close Contact With

What Can We Do To Make You Happier

SIGN HERE AFTER PRINTING

Signature

Date

1. Concerns:

2. Medications and/or Nutritional Supplements:

3. Dietary Intake For Past 2 Days Before Appointment:

Yesterday

Breakfast	Lunch	Dinner	Snacks

Day Before Yesterday

Breakfast	Lunch	Dinner	Snacks

PRINT COMPLETED FORM CLEAR FORM