BELDE CHIROPRACTIC & body shop

Nutrition Response Testing
Program Guidelines

1. MAKE APPOINTMENTS A PRIORITY

   You are expected to keep all appointments as scheduled in order to ensure maximum progress in your case. If for some reason you cannot make an appointment, please call at least 24 hours in advance. You will need to reschedule that appointment for the same week and not fall into the following week.

   Follow-up visits generally take 10 minutes or less. To save time on your visits, write down your questions and get in contact with our Patient Advocate for further discussion.

3. FOOD INTAKE TRACKING IS A MUST

   Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Tracking on your phone works too! Make it a habit to record all food consumed, when consumed and not wait until the end of the day or later. This will ensure accurate information for the doctor.

4. CONSISTENCY IS KEY

   Try not to miss any doses of your supplements. Missed doses will slow down improvement and extend the time it takes to complete your program. If you miss a dose, you can make it up at your next dose but if this happens repeatedly, let the doctor know so your supplement schedule can be modified or reach out to our patient advocate for tips on remaining consistent.

5. REPAIR TAKES TIME

   Please keep in mind that our nutritional products DO NOT cause side effects as they are not drugs. Occasionally after starting a nutritional program, you may feel a temporary worsening or even feel sick. If this occurs, do not cancel your appointment. Immediately call the clinic. Sometimes these flare-ups are actually a Healing Crisis, which indicates your body is starting to heal by eliminating toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations, if they occur. It is often most important to come in when you're not feeling your best so we can fine-tune your program and help you address the underlying cause of the problem.

6. COMMITMENT IS NECESSARY

   Please consider all the dynamics in your life that could interfere with or prevent you from doing or completing your Health Improvement Program. If you need assistance on working out how to handle any obstacles in your quest for better health, please stay in communication with our patient advocate.

This ***might*** just change your life.

BELDE CHIROPRACTIC & body shop

Nutrition Response Testing
New Patient Form

CONTACT INFORMATION:

Date:	Email address:
Name:	Referred by:
Address (City, State, Zip):	Occupation and employer:
Primary phone: Work phone:	Birthdate:
Marital status (circle one): Single Married Widowed	Preferred communication style (circle one): Text Email Call

HEALTH OVERVIEW:

Overall health (circle one): Excellent / Good / Fair / Poor	Chief complaint (reason you are here):	Previous treatments for this complaint:
Any other complaints or problems?		
Current medications:	Current nutritional supplements:	Name and date of last physician/health care visit Physician: Approx. date:
Do you smoke, drink coffee or alcohol? Smoke: _____ x per day Coffee: _____ cups per day Alcohol: _____ drinks per week	List any major illnesses with approx. dates: ______________________________ ______________________________ ______________________________	Are there any pets you're in close contact with? Please list the type of animal: ____ ____ ____
List names and ages of children, if any: ____ ____ ____		Any family history of serious illness (circle one): Cancer Diabetes Heart Other: _______
Past accidents or injuries: Type: _________________________ Date: __________ Type: _________________________ Date: __________ Type: _________________________ Date: __________ Type: _________________________ Date: __________	Add more explanation, if needed:	

Nutrition Response Testing
Permission & Authorization Form

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Belde Chiropractic Clinic 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, 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 imbalance in these areas could cause or contribute to various health problems.

I understand that 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.

No promise or guarantee has been made regarding the results 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 as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

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

Date: __________

Print Name: ________________________

Signed: ____________________________

(If minor, signature of parent or guardian required)

Witness: ____________________________

Nutrition Response Testing
Heart Rate Variability Authorization

I give Belde Chiropractic and Body Shop permission to record the sound of my heart and to create a graph of that sound on the Heart Rate Variability (HRV) machine.

I understand and acknowledge that the HRV machine is a general wellness cardiac stress monitor, not an electrocardiograph like those used in hospitals or by physicians and that it is not capable of diagnosing heart conditions and is not in any way a substitute for such a device.

I further understand that the HRV machine has not been reviewed or cleared by the US Food and Drug Administration.

I understand that if I have or believe I have a heart condition, that I should see a physician qualified to evaluate and treat that condition. Any suggested nutritional or dietary advice is not intended as treatment or therapy for any disease or symptom of disease. Nutritional counseling, supplement recommendations, and exercise considerations provided to me are to support the normal physiological processes of the body.

I understand that any techniques, treatments, or lifestyle changes suggested after the use of this device should be undertaken only with the guidance of a licensed physician, therapist, or healthcare practitioner.

The findings from this device can be used to support, but should not be used in place of sound medical therapies and recommendations. I am giving permission to Belde Chiropractic and Body Shop to share my graph with other practitioners for educational purposes only so long as my name and other personal information are removed.

By signing I agree to the above.

Date: __________

Print Name: ________________________

Signed: ____________________________

(If minor, signature of parent or guardian required)