Nutrition Response Testing

at North Isle Wellness Center
93 Miller Place Road
Miller Place, NY 11764
(631)476-4051
www.northislewellness.com

Thank you for your interest in Nutrition Response Testing offered at the North Isle Wellness Center.

Your appointment date and time is _____

Kindly arrive within 30 minutes of your scheduled appointment time so that we may review your paperwork and get started promptly. We take pride in our scheduling therefore no patient is left waiting.

Enclosed please find the follow: New Patient In-take Form, Symptom Survey, Authorization to Test, and brochure. Prior to your appointment be sure to complete both pages of the New Patient Intake form and sign the second page. Symptom Survey: Read the instructions **carefully** and color in all the dots that apply. If you are unsure of a question then circle it. Feel free to elaborate on any questions. On the second page write in the five main complaints in their order of importance to you. Finally, read and sign the authorization form allowing us to test you.

For testing purposes wear clothing that has two parts, like shirt and pants, which will allow us to place a heart monitor around your bare chest. Ladies, please avoid dresses.

We strongly suggest that you call our office within 24 hours should you need to change or cancel your appointment.

Should you have any questions, please feel free to contact me. I look forward to meeting you and help you on your way to a better quality of life.

Nadine Ianniello
Patient Advocate

Nutrition Response Testing New Patient In-Take

Please Print Clearly

Patient Name _____

If Under 18 Parent/Guardian Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Shipping Address _____

_____

Home Phone (____) ____-_____ Cell Phone (____) ____-_____

e-mail 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 _____

_____

Any other conditions that concern you _____

_____

_____

Current medications or drugs: (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):

_____

Do you have any problems swallowing pills or capsules? Yes/No

Which do you prefer? Circle all that apply Tablets Capsule Liquids

Are you Gluten Intolerant? Yes/No

Are you Lactose Intolerant? Yes/No

Are you Vegetarian or Vegan? Yes/No

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

Cigarettes _____ Coffee _____ Alcohol _____

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? _____

_____

Patient Signature _____ Date _____

If under 18 Parent/Guardian Signature

_____ Date _____

SYMPTOM SURVEY FORM

Symptom Survey Maestro

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
	1	2	3	
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 (emale)

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. _____

Nutrition Response Testing

at North Isle Wellness Center

Permission and Authorization

Please read carefully before signing

I specifically authorize the natural health practitioners at the North Isle Wellness Center to perform a Nutrition Response Testing health analysis and to develop a natural 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" of 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 organ responses 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: _____

Address:_____

City _____ State_____ Zip_____

Phone: (____) _____ - _____

Signed:_____

(If minor, signature of parent or guardian required)

Witness:_____