LITTLE ROCK CHIROPRACTIC CLINIC

1100 West 3rd St.
Little Rock, Arkansas 72201
Phone: 501-371-0022 Fax: 501-371-0810

Application for Nutrition Response Testing

Please print this form, fill out completely, and
Fax to us at 501-371-0810, or bring to our location in person.

Please print clearly:

Name_____Date_____

Address_____Apt. #_____

City_____State_____Zip_____

Home Phone (_____)_____ -_____ Office Phone (_____)_____- _____

Cell Phone (____)_____- _____

Email address_____

Referred By: _____

Occupation _____

Employer Name and Address _____

Date of Birth _____ Age____Sex: Male ☐ Female ☐ Height_____Weight_____

Number of Children _____

Please check or circle: ☐Married ☐Single ☐Widowed ☐Divorced ☐ Separated

Overall health: ☐Excellent | ☐Good | ☐Fair | Other:_____

Chief complaint (reason you are here): (Use separate sheet if more room needed)

_____

_____

Previous treatments for this complaint:_____

_____

Other complaints or problems:_____

_____

Current Medications/Drugs being taken:_____

_____

List Any Drug Allergies:_____

_____

Are you currently under the care of a physician or other health care professionals?
If yes, please give name and last date of visit:

_____

_____

Nutritional supplements you are taking:

_____

_____

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

Cigarettes_____ Coffee_____ Alcohol_____

HISTORY:

List any major illnesses (with approximate dates):

_____

_____

List any surgery or operations with approx. date:

_____

_____

Past accidents or injuries:

_____

_____

Marital Status: Single Name of Spouse (if married)_____

Name of Child(ren): Age Sex Any physical conditions or concerns?

_____

_____

_____

_____

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: _____

NUTRITIONAL EVALUATIONAL SERVICE
Little Rock Chiropractic Clinic, PA

PATIENT_____ AGE_____ DOCTOR_____ DATE_____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE – Support Parasympathetic

1 –	Acid foods upset	8 –	Gag Easily	15 –	Appetite reduced
2 –	Get chilled, often	9 –	Unable to relax, startles easily	16 –	Cold sweats often
3 –	"Lump" in throat	10 –	Extremities cold, clammy	17 –	Fever easily raised
4 –	Dry mouth-eyes-nose	11 –	Strong light irritates	18 –	Neuralgia-like pains
5 –	Pulse speeds after meal	12 –	Urine amount reduced	19 –	Staring, blinks little
6 –	Keyed up - fail to calm	13 –	Heart pounds after retiring	20 –	Sour stomach frequent
7 –	Cuts heal slowly	14 –	"Nervous" stomach		

GROUP TWO – Support Sympathetic

21 –	Joint stiffness after arising	29 –	Digestion rapid	37 –	"Slow starter"
22 –	Muscle-leg-toe cramps at night	30 –	Vomiting frequent	38 –	Get "chilled" infrequently
23 –	"Butterfly" stomach, cramps	31 –	Hoarseness frequent	39 –	Perspire easily
24 –	Eyes or nose watery	32 –	Breathing irregular	40 –	Circulation poor,
25 –	Eyes blink often	33 –	Pulse slow; feels "irregular"		sensitive to cold
26 –	Eyelids swollen, puffy	34 –	Gagging reflex slow	41 –	Subject to colds,
27 –	Indigestion soon after meals	35 –	Difficulty swallowing		asthma, bronchitis
28 –	Always seem hungry; feels "lightheaded" often	36 –	Constipation, diarrhea alternating		

GROUP THREE – Hypoglycemia

42 –	Eat when nervous	49 –	Heart palpitates if meals	53 –	Crave candy or coffee
43 –	Excessive appetite		missed or delayed		in afternoons
44 –	Hungry between meals	50 –	Afternoon headaches	54 –	Moods of depression -
45 –	Irritable before meals	51 –	Overeating sweets upsets		"blues" or melancholy
46 –	Get "shaky" if hungry	52 –	Awaken after few hours sleep	55 –	Abnormal craving for
47 –	Fatigue, eating relieves		- hard to get back to sleep		sweets or snacks
48 –	"Lightheaded" if meals delayed				

GROUP FOUR – Cardiovascular

56 –	Hands and feet go to sleep	63 –	Get "drowsy" often	68 –	Bruise easily, "black
	easily, numbness	64 –	Swollen ankles		and blue" spots
57 –	Sigh frequently, "air		worse at night	69 –	Tendency to anemia
	hunger"	65 –	Muscle cramps, worse	70 –	"Nose bleeds" frequent
58 –	Aware of "breathing		during exercise; get	71 –	Noises in head, or
	heavily"		"charley horses"		"ringing in ears"
59 –	High altitude discomfort	66 –	Shortness of breath	72 –	Tension under the
60 –	Opens windows in		on exertion		breastbone, or feeling
	closed room	67 –	Dull pain in chest or		of "tightness",
61 –	Susceptible to colds		radiating into left arm,		worse on exertion
	and fevers		worse on exertion		
62 –	Afternoon "yawner"				

SYMPTOM SURVEY FORM – PAGE 2

GROUP FIVE – Liver, Gallbladder, Intestines

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 SIX – Digestion of Protein

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 hours
104 – Mucous colitis or "irritable bowel"
105 – Gas shortly after eating
106 – Stomach "bloating" after eating

GROUP SEVEN – Endocrine System, HPA Axis

(A) – Hyperthyroid

107 – Insomnia
108 – Nervousness
109 – Can't gain weight
110 – Intolerance to heat
111 – Highly emotional
112 – Flush easily
113 – Night sweats
114 – Thin, moist skin
115 – Inward trembling
116 – Heart palpitates
117 – Increased appetite without weight gain
118 – Pulse fast at rest
119 – Eyelids and face twitch
120 – Irritable and restless
121 – Can't work under pressure

(B) – Hypothyroid

122 – Increase in weight
123 – Decrease in appetite
124 – Fatigue easily
125 – Ringing in ears
126 – Sleepy during day
127 – Sensitive to cold
128 – Dry or scaly skin
129 – Constipation
130 – Mental sluggishness
131 – Hair coarse, falls out
132 – Headaches upon arising wear off during day
133 – Slow pulse, below 65
134 – Frequency of urination
135 – Impaired hearing
136 – Reduced initiative

(C) – Hyper-Pit

137 – Failing memory
138 – Low blood pressure
139 – Increased sex drive
140 – Headaches, "splitting or rendering" type
141 – Decreased sugar tolerance

(D) – Hypo-Pit

142 – Abnormal thirst
143 – Bloating of abdomen
144 – Weight gain around hips or waist
145 – Sex drive reduced or lacking
146 – Tendency to ulcers, colitis
147 – Increased sugar tolerance
148 – Women: menstrual disorders
149 – Young girls: lack of menstrual function

(E) – Hyper Adrenals

150 – Dizziness
151 – Headaches
152 – Hot flashes
153 – Increased blood pressure
154 – Hair growth on face or body (female)
155 – Sugar in urine (not diabetes)
156 – Masculine tendencies (female)

(F) – Hypo Adrenals

157 – Weakness, dizziness
158 – Chronic fatigue
159 – Low blood pressure
160 – Nails, weak, ridged
161 – Tendency to hives
162 – Arthritic tendencies
163 – Perspiration increase
164 – Bowel disorders
165 – Poor circulation
166 – Swollen ankles
167 – Crave salt
168 – Brown spots or bronzing of skin
169 – Allergies - tendency to asthma
170 – Weakness after colds, influenza
171 – Exhaustion - muscular and nervous
172 – Respiratory disorders

SYMPTOM SURVEY FORM – PAGE 3

GROUP EIGHT

173 – Apprehension
174 – Irritability
175 – Morbid fears
176 – Never seems to get well
177 – Forgetfulness
178 – Indigestion
179 – Poor appetite
180 – Craving for sweets
181 – Muscular soreness
182 – Depression; feelings of dread
183 – Noise sensitivity
184 – Acoustic hallucinations
185 – Tendency to cry without reason
186 – Hair is coarse and/or thinning
187 – Weakness
188 – Fatigue
189 – Skin sensitive to touch
190 – Tendency toward hives
191 – Nervousness
192 – Headache
193 – Insomnia
194 – Anxiety
195 – Anorexia
196 – Inability to concentrate; confusion
197 – Frequent stuffy nose; sinus infections
198 – Allergy to some foods
199 – Loose joints

FEMALE ONLY

200 – Very easily fatigued
201 – Premenstrual tension
202 – Painful menses
203 – Depressed feelings before menstruation
204 – Menstruation excessive and prolonged
205 – Painful breasts
206 – Menstruate too frequently
207 – Vaginal discharge
208 – Hysterectomy/ovaries removed
209 – Menopausal hot flashes
210 – Menses scanty or missed
211 – Acne, worse at menses
212 – Depression of long standing

MALE ONLY

213 – Prostate trouble
214 – Urination difficult or dribbling
215 – Night urination frequent
216 – Depression
217 – Pain on inside of legs or heels
218 – Feeling of incomplete bowel evacuation
219 – Lack of energy
220 – Migrating aches and pains
221 – Tire too easily
222 – Avoids activity
223 – Leg nervousness at night
224 – Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

Little Rock Chiropractic Clinic, P. A.
1100 West Third Street
Little Rock, AR 72201
Phone 501-371-0022 Fax 501-371-0810
www.littlerockchiropractic.com

Check Out:
www.standardprocess.com

Little Rock Chiropractic Clinic
1100 West 3rd Street
Little Rock, Arkansas 72201

PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF
NUTRITION RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at *Little Rock 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" 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 reflexes can be used as an aid in 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:_____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Signed:_____

If minor, signature of parent or guardian required:_____

Patient Consent for Use and Disclosure
Of Protected Health Information

LITTLE ROCK CHIROPRACTIC CLINIC, P.A.

I hereby give my consent for Little Rock Chiropractic Clinic, P.A. (hereinafter referred to as "LRCC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

LRCC's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. A copy of this Notice is available upon request to Dr. Richard L. Riley or Denise Moix, our Privacy Officers, or any other LRCC staff member.

LRCC reserves the right to revise its Notice of Privacy Practices at any time and agrees to provide me a revised copy upon my request to LRCC.

With this consent, the LRCC may call (or text message) my home or other designated phone number on file and leave a message on voice mail or in person in reference to any items that assist LRCC in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, LRCC may mail to my home or other designated location on file any items that assist LRCC in carrying out TPO, such as patient statements.

With this consent, LRCC may e-mail to my home or other designated location on file any items that assist LRCC in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that LRCC restrict how it uses or discloses my PHI to carry out TPO. However, LRCC is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to LRCC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that LRCC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, LRCC may decline to provide treatment to me as permitted by Section 164.506 of the Code of Federal Regulations.

_____
Print Patient's Name

_____ _____
Print Name of Legal Guardian, if applicable Date

_____
Signature of Patient or Legal Guardian

☐ I have been given and am in receipt of LRCC's Notice of Privacy Practices. _____ ***(please initial)***

☐ I do not wish to receive a copy of LRCC's Notice of Privacy Practices. _____ ***(please initial)***

Little Rock Chiropractic Clinic
Financial Policy

Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any question you may have concerning an account statement.

Our staff checks your insurance benefits and takes that information into consideration when collecting for the appointment. However, the sum we request at checkout is only an ***estimate*** of your out-of-pocket responsibility based on our understanding of your insurance benefits. You may owe more than collected, or you may have paid more than required by your plan. You will receive a statement of account showing your balance due, or we will send you a check for an account credit balance.

Cancellation and Missed Appointment Policy
We understand that, on occasion, appointments must be changed or cancelled. You may call our office at any time, night or day, to cancel or reschedule an appointment by leaving a message on our answering machine. Failure to do so, will result in a $10.00 fee.

Auto accidents/workers compensation
Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in you becoming responsible to pay the balance.

Our office will send appropriate workers compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our statement.

Collections and Outstanding Balances
We do our best to work with patients on collection of account balances. We ask that a patient pay a minimum of $25 per month to satisfy their account balance. If a patient has an account balance over 60 days old with no payment made by the patient in the last 60 days, the account will be referred to an outside collection agency. Accounts referred to an outside collection agency will be subject to a collection fee of 40%, which will be added to the total balance due. If your account is sent to court for collection, a total of 50% will be added to the balance due.

Returned Check Fee
There will be a fee of $25.00 for any returned checks to our office.

Signing below acknowledges that you have read and understand the above-stated policies.

_____ _____

Signature of Patient or Patient Representative Date