



NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ **Date** _____

Address _____ **Apt.#** _____

City _____ **State** _____ **ZIP** _____

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

E-mail address: _____

Occupation _____ **Employer** _____

Date of Birth _____ **Age** ____ **Sex:** M/F **Height** ____ **Weight** ____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

REFERRED BY: _____

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

Previous treatments for this complaint:

Current medications/drugs being taken: (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):

K. Christine Lim, D.C., B CAO
Garry T. Krakos, D.C., B CAO
6120 Brandon Avenue., Suite 203
Springfield, Virginia 22150
(703)644-2222

Nutritional supplements you are taking:

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

Cigarettes _____ Coffee _____ Alcohol _____ Soda _____

HISTORY:

List any major illnesses (with approx. dates):

List any surgery or operations (with approx. date):

Past accidents, auto accidents and/or other injuries:

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:

Patient/Guardian (Please Print)

Patient/Guardian (Signature)

Date: _____

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New Patient Introduction Form
Dietary intake for 2 days before appointment:

	Day 1:	Day 2:
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		
Notes:		

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Authorization Form:

Regarding the use of Nutrition Responses Testing

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Spine Arts Center 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 to “cure” 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 any other medical conditions, and that these are not being tested 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, by rather I understand that Nutrition Response Testing is a means by which the body’s natural organ response 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.

Patient/Guardian (Please Print)

Patient/Guardian (Signature)

Date: _____

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PLEASE INITIAL NEXT TO EACH NUMBER.

- _____ 1. 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, we require a minimum 24 hour advanced notice before cancellation or rescheduling. You will need to reschedule that appointment for the SAME week and not fall into the following week. Short notice or no notice may also incur an office visit charge.

- _____ 2. Follow-up visits generally take 10 minutes or less. Extended visits, though rarely needed, are charged proportionally. To save time on your visits, write down your questions and let the practitioner know about these at the beginning of the visit. In between visits, it is highly recommended that you take up any questions with the Patient Advocate, either by phone or in person, since there is no charge for time spent with the Patient Advocate.

- _____ 3. Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Make it a habit to do it this way and not wait until the end of the day or later. This will ensure accurate information for the practitioner.

- _____ 4. 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 make it up at a point later in the day. If this happens repeatedly, let the practitioner know so your supplement schedule can be modified.

- _____ 5. 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 office. Sometimes these “flare-ups” are actually a “Healing Crisis” which indicates your body is starting to heal by throwing off toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations much more smoothly, if they even occur. When you are not doing well is when it is often most important to come in so we can fine-tune your program and help you correct the underlying cause of the problem more rapidly.

- _____ 7. 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 in working out how to handle any obstacles in your quest for better health, please stay in communication with the patient advocate.

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