The Natural Path, Ltd.

New Client Information Form

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General Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive an email copy of our monthly newsletter? Yes [ ] No [ ]

Shipping Address (if different from above) Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work/Cell Phone (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Contact preference: Text [ ] Call [ ]

Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Sex: M/F Height \_\_\_\_\_Weight \_\_\_\_\_

Marital Status: S M D W Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children (if any): \_\_\_\_\_\_\_\_\_

Overall Health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health of Spouse (if applicable): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medication (list medication & type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Food (list food & type of reaction):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint (reason you are here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Releases

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**Authorization for the use of Nutritional Kinesiology**

I specifically authorize the natural health practitioners at The Natural Path, Ltd. to perform a non-invasive health analysis using Nutritional Kinesiology. The purpose of this exam is to develop a natural health improvement program for me, which may include dietary modifications, nutritional supplementation, natural body and system cleanses, as well as ongoing education. The purpose of which is to improve my overall health, and not for the purpose of treatment or “cure” of any known or unknown disease.

I understand that Nutritional Kinesiology is a safe, non-invasive, natural approach for analyzing the body's physical and nutritional needs as well as identify possible deficiencies or imbalances in areas that could cause or contribute to my various health concerns.

I understand that Nutritional Kinesiology is not a method for diagnosing or treating any known or unknown disease including conditions such as cancer, diabetes, heart disease, 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 Nutritional Kinesiology or any natural health, nutritional or dietary program recommended. I understand that Nutritional Kinesiology is a means by which the body's natural reflexes can be used to aid in determining possible nutritional imbalances, so that a safe natural program can be developed for the purpose of bringing about a more optimal state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Sign and Date (If minor, signature of parent or guardian required)

The Natural Path, Ltd.

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**Authorization for the use of Neuro Emotional Technique (NET®)**

The information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client’s consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: <http://www.dora.state.co.us/mentalhealth/Statute.pdf>

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Sign and Date (If minor, signature of parent or guardian required)

**Authorization for the use of Body Work and Cold Laser Therapy**

I, the undersigned client, hereby authorize The Natural Path, Ltd. appointed staff to administer such therapy as is necessary. I hereby certify that I understand the advantages and possible complications. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Sign and Date (If minor, signature of parent or guardian required)

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**Regarding Your Pharmaceutical Medications:**

At The Natural Path, Ltd., we DO NOT prescribe or “un-prescribe” any pharmaceutical medications. All dosing of your prescription medications must be done through the doctor who prescribed them for you.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Regarding Insurance Claims:**

This office is NOT an approved direct provider to insurance companies. As such, we do not provide a Medical Necessity letter to any insurance companies for reimbursement of services or products.

We will provide you with a copy of your file, if needed for reimbursement, for a $5.00 documentation preparation fee. A copy of your receipt in payment for product and services will be provided to you following each of your visits.

Client (printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_