Gilead Healing Center

NEW PATIENT INFORMATION FORM

Please print clearly:

Name ______________________________ Date ______________

Address ______________________________ Apt.# ______________

City ______________________ State ____________ ZIP ______________

Home Phone (___) ____-______Work 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 ____

____

Other complaints or problems: (use separate sheet if needed) ________________________

____

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):

____

Nutritional supplements being taken: ______________________________________

Do you smoke, chew tobacco, use marijuana, CBD, drink coffee or alcohol? (if yes indicate how much) Cigarettes/Vape _________ Coffee _________________

Alcohol ________________ Marijuana ________________ CBD ____________________

HISTORY:

List any major illnesses (with approx. dates): ________________________________

____

List any surgery or operations with approx. date: ______________________________

____

Past Accidents or injuries: ____

____

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Marital Status: S M D W Name of Spouse ______________________

Describe health of spouse: Excellent / Good / Fair / Poor / Other: ___________________

Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
________________	____	M/F	________________
________________	____	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:
____

PLEASE READ BEFORE SIGNING:

I specifically authorize Helena Miller to perform a nutrition 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 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 testing is not a method for "diagnosing" or "treating" any disease including conditions of cancer, HIV, 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 testing or any natural health, nutritional or dietary programs recommended, but rather I understand that nutrition 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 understood the foregoing. This permission form applies to subsequent visits and consultations

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SIGNED: ______________________________ DATE: ____________________

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