

REGISTRATION FOR NUTRITIONAL CONSULTATION

Gonstead Spine Institute - 2735 W. Union Hills Dr. Phoenix, AZ 85027 - Phone (602)-973-1630

Patient Information

Date _____

Patient Name _____
Last Name

First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex Male Female

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for ____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone _____

Spouse's name _____

Birthdate _____

Spouse's Employer _____

How were you referred? _____

Briefly state what is your hope/expectation of this consultation?

Phone Numbers

Cell (____) _____ Home (____) _____

Best time to reach you _____

In case of emergency, contact

Name _____ Relationship _____

Home (____) _____ Work (____) _____

Informed Consent to Treat

PLEASE READ BEFORE SIGNING:

I specifically authorize Dr. Scott Timko and any of the health practitioners at Gonstead Spine Institute to perform a nutritionally based health analysis and 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.**

Safe and non-invasive natural methods of analyzing the body's physical and nutritional needs may be utilized including but not limited to a case history, symptom assessment forms, kinesiology and review of any pertinent lab work.

I understand that these procedures are not a method for "diagnosing" or "treating" 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 this nutritional counseling or any natural health, nutritional or dietary programs recommended. I understand that this nutritional counseling is a means to determine 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 and that this permission applies to subsequent visits and consultations.

Date: _____

Signed: _____

(If minor, signature of parent or guardian required)