What is Nutrition Response Testing (NRT)?

- A Nutrition Response Test is a non-invasive and painless discovery meeting for your organs.
- The test determines which organs aren't functioning properly by monitoring the strength of specific reflexes while in contact with them.
- Your reflex strength is directly connected to the health of the corresponding organ in your body, and the cause of your symptoms.
- If your organs become weakened by nutrient deficiencies, food sensitivities, or toxic substances, your neurologic reflex will reflect that.
- Dr. Innaimo will lightly press on the different acupuncture points (reflex locations) that are related to specific organs or glands, while also checking a muscle group.

What is the Doctor Looking For?

- The Nutrition Response Test will single out the exact stressor inside the body by observing your reflex strength when the possible stressor is held in your hand.

Possible stressors include:

- Toxic metals, Mold, Parabens, Food sensitivities, Bacteria, Fungi, Viruses, Parasites, Mold and Everyday chemicals.
- Your body's responses provide the insight needed for the doctor to recommend a specific and individualized nutrition and supplement program to help return you to your optimal health.

Is Nutrition Response Testing Accurate?

- It's not uncommon to have doubts about something like this. We are raised to believe that medications are our best chance to restore our health issues.
- So, is Nutrition Response Testing accurate? Absolutely.
- NRT is a highly scientific and clinically proven method of determining the underlying cause of many health conditions, including:
- Hormonal imbalances, Digestive issues, Thyroid problems, Candida, Weight problems, and more.

Patients who adhere to their individualized nutrition programs usually begin to notice positive changes within just 4-6 weeks.

Daily Record of Food Intake | Your diet may be the key to better health.

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Standard Process®
WHOLE FOOD NUTRIENT SOLUTIONS

Name:

Day 1—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK *Time:*	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 2—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK *Time:*	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 3—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Notes:

Day 4—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 5—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 6—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Day 7—Date:

BREAKFAST Time:	**LUNCH** Time:	**DINNER** Time:
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK Time:	**MIDDAY SNACK** Time:	**NIGHTTIME SNACK** Time:
Snack:		
Bowel movements (number & consistency) :	**Hours of sleep:**	**Quality of sleep:** (good) 1 2 3 4 5 (poor)

Innaimo Clinic of Chiropractic

HEALTH & NUTRITION

NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

Shipping Address _____

Home Phone: _____ Work Phone _____

Email 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 you are taking: _____

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

Cigarettes _____ Coffee _____ Alcohol _____

Innaimo Clinic of Chiropractic

HEALTH & NUTRITION

NEW PATIENT INFORMATION FORM

Name _____ Date _____

HISTORY:

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

_____

List any surgery or operations (with approx. Dates): _____

_____

Past accidents and injuries: _____

_____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ___

Name of child	Age	Sex M / F	Any physical conditions or concerns?
_____	____		_____
_____	____	M / F	_____
_____	____	M / F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes /

Heart / Other _____

Any household pets or others animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

SIGNED: _____ DATE: _____

INNAIMO CLINIC OF CHIROPRACTIC

380 Main St # 5, Watertown, CT 06795 Phone (860)274-8858

PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF
NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at The Innaimo 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 organ responses 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.

Date: _____

Print Name: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This includes missing or cancelling an appointment with out 24 hours' notice.

PATIENT'S NAME:

_____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD # _____

EXPIRATION DATE: _____/_____ VERIFICATION CODE (3 or 4 DIGITS) _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Innaimo Clinic of Chiropractic to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement.
Missed appointments or appointments cancelled without 24 hours' notice will be charged the next business day.
I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date