The Natural Path
4605 Pembroke Lake Circle, Suite 103
Virginia Beach, VA 23455
757-478-4455
www.naturalpath-vb.com

Global Consent for Natural Health Consultation

I, _____ do consent to examination and Muscle Response Testing (Kinesiology) or Iridological Examination, Light Touch Massage to include Nerve Energy Alignment Treatment (NEAT Therapy), Reflexology, Ionic Foot Detox Treatment, Ear Candling, and the use of herbal treatments, topically and/or Homeopathic substances to be used in the course of my Natural Health Consultation.

I further hold The Natural Path, and Carl Fusco, ND, NMD, and Diana Pengitore, ND, blameless for any reactions to any procedures or products used in the course of Natural Health Consultations. I give this consent freely, and without any mental reservation or purpose of evasion, to continue until such time as I cease to be a client of The Natural Path and Carl Fusco ND NMD and Diana Pengitore, ND, or otherwise revoke my consent.

I understand that the advice given by The Natural Path is in no way intended to diagnose or treat any medical problems, nor is it intended to supplant any medical doctor's advice or treatment plan.

Given under my hand this ____ day of _____, 20____.

_____

Client's Signature

_____

Witnessed

Carl Fusco, ND NMD D
Diana Pengitore, ND

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Information Sheet (Please Print)

Name: _____

Address: _____
_____
_____
_____

Telephone:
Work _____
Home _____
Cell _____

Optional:
Email _____
Fax _____

Whom may we thank for your referral?

Name/ Relationship _____
Address _____
City/State/Zip _____
How did you hear about us? _____

Emergency Contact Information:
Name/Relationship _____
Telephone _____

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Health Questionnaire

Please answer the following questions as honestly as possible. This information is necessary to best assess your general health and aid you in achieving a natural and healthy lifestyle. All answers are held in strict confidence. As no records or copies of records are kept on premises, it is recommended that you keep this record in a safe place, with control over access. Please feel free to share this information with an allopathic physician should the need arise.

Date: Age today: Sex:

Smoker: ☐ yes ☐ no Alcohol use: ☐ yes ☐ no Coffee/caffeine: ☐ yes ☐ no

List medications currently taking (include vitamins and supplements/herbals):

List any medical diagnoses, if known, or describe to the best of your ability:

Family History:

Write the ages of your living relatives, if known. Check the box if they are deceased, and write their age at time of death and cause, if known.

Father ☐ _____ Mother ☐ ____ Brother ☐ _____ Sister ☐ _____

Has any family member ever had any of the following conditions?: *Please check the box if yes*

Diabetes		HIV/AIDS		Seasonal Allergies	
Arthritis		Depression		Fibromyalgia/Chronic Fatigue	
High Blood Pressure		Asthma		Anxiety	
Kidney Disease		Osteoporosis		Alzheimer's	
Hepatitis ABC		Cardiac Disease/Stroke		Cancer	
Gall Bladder Disease		Seizures		Cholesterol Issues	

What is your reason for today's visit?

How long have you had this problem?

Are you affiliated with a Local, State, or Federal Agency? Yes ☐ No ☐

If so, in what capacity?

Signed _____ Date _____