

Pamela Hortn, Ph.D.
1618 Williams Drive #6
Gorgetown, TX 78629
(512) 931-2162

New Patient Introduction Form

Patient Name:

Date:

1. Chief Concerns:

2. Medications and/or Nutritional Supplements currently on:

3. Dietary Intake for 2 days before appointment:

Breakfast:

Breakfast:

Snacks:

Snacks:

Lunch:

Lunch:

Snacks:

Snacks:

Dinner:

Dinner:

Snacks:

Snacks:

Pamela Horton, Ph.D.
NEW PATIENT INFORMATION FORM

Page 1 of 2

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Home Phone (____) ____-____ Work 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 you are taking: _____

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

Cigarettes _____ Coffee _____ Alcohol _____

=====

Office Use Only:

NEW PATIENT INFORMATION FORM

Page 2 of 2

Name: _____ Date _____

HISTORY:

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

List any surgery or operations with approx. date: _____

Past Accidents or injuries: _____

=====

Marital Status: S M D W Name of Spouse _____

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

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	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:

What can we do to make you happier? _____

SIGNED: _____ DATE _____

Pamela Horton, Ph.D.

1618 Williams Drive #6 Georgetown, TX 782628 (512) 868-0548

**PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF
NUTRITION RESPONSE TESTING™**

PLEASE READ BEFORE SIGNING:

I specifically authorize Pamela Horton, Ph.D. and/or her nutritional associates 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 reflexes 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: _____

Pamela Horton, Ph.D.

1618 Williams Drive #6

Georgetown, TX 78628

(512) 868-0548

PROGRAM GUIDELINES

Please place this in an obvious location as a pleasant reminder.

- 1. You are expected to keep all appointments as scheduled in order to ensure maximum progress in your case. If for some reason you cannot make an appointment, please call at least 24 hours in advance. You will need to reschedule that appointment for the SAME week and not fall into the following week.*
- 2. Follow-up visits generally take 10 minutes or less. Extended visits, though rarely needed, are charged proportionally. To save time on your visits, write down your questions and let doctor know about these at the beginning of the visit. In between visits, it is highly recommended that you take up any questions with the Patient Advocate, either by phone or in person, since there is no charge for time spent with the Patient Advocate.*
- 3. Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Make it a habit to do it this way and not wait until the end of the day or later. This will ensure accurate information for the doctor.*
- 4. TRY NOT to miss any doses of your supplements. Missed doses will slow down improvement and extend the time it takes to complete your program. If you miss a dose, you can make it up at your next dose. If this happens repeatedly, let the doctor know so your supplement schedule can be modified.*
- 5. Please keep in mind that our nutritional products DO NOT cause “side effects” as they are not drugs. Occasionally after starting a nutritional program, you may feel a temporary worsening or even feel “sick.” If this occurs, do NOT cancel your appointment. Immediately call the office. Sometimes these “flare-ups” are actually a “Healing Crisis” which indicates your body is starting to heal by throwing off toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations much more smoothly, if they even occur. When you are not doing well is when it is often most important to come in so we can fine-tune your program and help you correct the underlying cause of the problem more rapidly.*
- 6. It is REQUIRED that you attend at LEAST one of our public education workshops within the first four weeks of your program. This is for YOUR own benefit. Each lecture we do is approximately 1 hour so that is like getting six office visits ABSOLUTELY FREE. We encourage you to bring a friend or family member who is supportive of you coming to our office for care. This would allow them to see and better understand what exactly it is we do. In addition, it may even encourage them to become a patient themselves. This would be to your benefit because every time people do a program as teammates they get BETTER RESULTS and FASTER IMPROVEMENTS.*
- 7. Please consider all the dynamics in your life that could interfere with or prevent you from doing or completing your health improvement program. If you need assistance in working out how to handle any obstacles in your quest for better health, please stay in communication with the patient advocate.*

SYMPTOM SURVEY FORM

NAME _____ DOCTOR _____ DATE _____

AGE _____ SEX M _____ F _____

Phone # (_____) _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
(1) for **MILD** symptoms
(2) for **MODERATE** symptoms
(3) for **SEVERE** symptoms
Leave the box **BLANK** if it does not apply to you!

GROUP 1

- 1 Acid foods upset
- 2 Get chilled, often
- 3 "Lump" in throat
- 4 Dry mouth-eyes-nose
- 5 Pulse speeds after meals
- 6 Keyed up - fail to calm
- 7 Cuts heal slowly
- 8 Gag easily
- 9 Unable to relax; startles easily
- 10 Extremities cold, clammy
- 11 Strong light irritates
- 12 Urine amount reduced
- 13 Heart pounds after retiring
- 14 "Nervous" stomach
- 15 Appetite reduced
- 16 Cold sweats often
- 17 Fever easily raised
- 18 Neuralgia-like pains
- 19 Staring, blinks little
- 20 Sour stomach frequent

GROUP 2

- 21 Joint stiffness after arising
- 22 Muscle-leg-toe cramps at night
- 23 "Butterfly" stomach, cramps
- 24 Eyes or nose watery
- 25 Eyes blink often
- 26 Eyelids swollen, puffy
- 27 Indigestion soon after meals
- 28 Always seems hungry; feel "lightheaded" often
- 29 Digestion rapid
- 30 Vomiting frequent
- 31 Hoarseness frequent
- 32 Breathing irregular
- 33 Pulse slow; feels "irregular"
- 34 Gagging reflex slow
- 35 Difficulty swallowing
- 36 Constipation, diarrhea alternating
- 37 "Slow starter"
- 38 Get "chilled" infrequently
- 39 Perspire easily
- 40 Circulation poor, sensitive to cold
- 41 Subject to colds, asthma, bronchitis

GROUP 3

- 42 Eat when nervous
- 43 Excessive appetite
- 44 Hungry between meals
- 45 Irritable before meals
- 46 Get "shaky" if hungry
- 47 Fatigue, eating relieves
- 48 "Lightheaded" if meals delayed
- 49 Heart palpitates if meals missed or delayed
- 50 Afternoon headaches
- 51 Overeating sweets upsets
- 52 Awaken after few hours sleeps - hard to get back to sleep
- 53 Crave candy or coffee in afternoons
- 54 Moods of depression - "blues" or melancholy
- 55 Abnormal craving for sweets or snacks

GROUP 4

- 56 Hands and feet go to sleep easily, numbness
- 57 Sigh frequently, "air hunger"
- 58 Aware of "breathing heavily"
- 59 High altitude discomfort
- 60 Opens windows in closed room
- 61 Susceptive to colds and fevers
- 62 Afternoon "yawner"
- 63 Get "drowsy" often
- 64 Swollen ankles worse at night
- 65 Muscle cramps, worse during exercise; get "charley horses"
- 66 Shortness of breath on exertion
- 67 Dull pain in chest or radiating into left arm, worse on exertion
- 68 Bruise easily, "black/blue" spots
- 69 Tendency to anemia
- 70 "Nose bleeds" frequent
- 71 Noises in head or "ringing in ears"
- 72 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

- 73 Dizziness
- 74 Dry Skin
- 75 Burning feet
- 76 Blurred vision
- 77 Itching skin and feet
- 78 Excessive falling hair
- 79 Frequent skin rashes
- 80 Bitter, metallic taste in mouth in mornings
- 81 Bowel movement painful or difficult
- 82 Worries, feels insecure
- 83 Felling queasy; headache over eyes
- 84 Greasy foods upset
- 85 Stools light-colored
- 86 Skin peels on foot soles
- 87 Pain between shoulder blades
- 88 Use laxatives
- 89 Stools alternate from soft to watery
- 90 History of gallbladder attacks or gallstones
- 91 Sneezing attaches
- 92 Dreaming, nightmare type bad dreams
- 93 Bad breath (halitosis)
- 94 Milk products cause distress
- 95 Sensitive to hot weather
- 96 Burning or itching anus
- 97 Crave sweets

GROUP 6

- 98 Loss of taste for meat
- 99 Lower bowel gas several hours after eating
- 100 Burning stomach sensations, eating relieves
- 101 Coated tongue
- 102 Pass large amounts of foul-smelling gas
- 103 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 Mucus colitis or "irritable bowel"
- 105 Gas shortly after eating
- 106 Stomach "bloating" after eating

GROUP 7**(A)**

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

(B)

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Metal sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7 (continued)**(C)**

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

(D)

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

(E)

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

(F)

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma
- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

FEMALE ONLY

- 173 Very easily fatigued
- 174 Premenstrual tension
- 175 Painful menses
- 176 Depressed feeling before menstruation
- 177 Menstruation excessive and prolonged
- 178 Painful breasts
- 179 Menstruate too frequently
- 180 Vaginal discharge
- 181 Hysterectomy/ovaries removed
- 182 Menopausal hot flashes
- 183 Menses scanty or missed
- 184 Acne, worse at menses
- 185 Depression of long standing

MALES ONLY

- 186 Prostate trouble
- 187 Urination difficult or dribbling
- 188 Night urination frequent
- 189 Depression
- 190 Pain on inside of legs or heels
- 191 Feeling of incomplete bowel evacuation
- 192 Lack of energy
- 193 Migrating aches and pains
- 194 Tire too easily
- 195 Avoid activity
- 196 Leg nervousness at night
- 197 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Pre-Therapy Testing *

Instructions: This packet contains three self-assessment tests which measure depression, anxiety, and satisfaction in personal relationships, respectively. Please complete each one and bring them to your therapist at the initial evaluation. They will only require a few minutes.

Your therapist may ask you to take these tests once a week throughout the therapy. If so, you will be given a fresh set of tests along with answer sheets and scoring keys at your first session. The tests are easy to complete and can help you and your therapist accurately track your progress.

Your therapist may also ask you to complete a fourth test called the Empathy Scale between sessions. This will give you a chance to indicate what you liked and disliked about your most recent session. This information can be invaluable, and will often make the therapy much more meaningful and rewarding.

Burns Depression Checklist *

Instructions: Place a check (✓) in the box to the right of each of the 15 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

	0—NOT AT ALL	1—SOMEWHAT	2—MODERATELY	3—A LOT
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look bleak or hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a loser?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability and frustration: Have you been feeling angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a lot about your health?				
15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead? **				
Total Score on items #1 - #15 →				

Burns Anxiety Inventory *

Instructions: Place a check (✓) in the box to the right of each of the 33 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

CATEGORY I: ANXIOUS FEELINGS

	0—NOT AT ALL	1—SOMEWHAT	2—MODERATELY	3—A LOT
1. Anxiety, nervousness, worry or fear				
2. Feeling things around you are strange or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stress, "uptight" or on edge				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of illnesses, heart attacks or dying				
14. Fears of looking foolish in front of others				
15. Fears of being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible will happen				

(continue on next page)

Burns Anxiety Inventory *

Instructions: Place a check (✓) in the box to the right of each of the 33 symptoms to indicate how much this type of feeling has been bothering you in the past several days.

CATEGORY III: PHYSICAL SYMPTOMS

	0—NOT AT ALL	1—SOMEWHAT	2—MODERATELY	3—A LOT
18. Skipping, racing or pounding of the heart				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				
Total Score on Items #1 - #33 →				

Relationship Satisfaction Scale *

Instructions: Place a check (✓) in the box to the right of each category that best describes the amount of satisfaction you feel in your closest relationship.

	0 - very dissatisfied	1 - moderately dissatisfied	2 - slightly satisfied	3 - neutral	4 - slightly satisfied	5 - moderately satisfied	6 - very satisfied
1. Communication and openness							
2. Resolving conflicts and arguments							
3. Degree of affection and caring							
4. Intimacy and closeness							
5. Satisfaction with your role in the relationship							
6. Satisfaction with the other person's role in the relationship							
7. Overall satisfaction with your relationship							
Total Score on Items #1 - #7 →							

Note: Please indicate who you had in mind when filling out this test:

Please indicate the type of relationship (spouse, colleague, friend, etc.):
