

Spring of Life, Inc.
d/b/a

Donna DiMarco Nutrition Counseling

2605 East Atlantic Blvd., Suite 200A
Pompano Beach, Florida 33062
954-941-8558 Fax 954-941-8220
donna@havehealthnow.com

I, _____ the undersigned, in consideration of participation in the Spring of Life Inc. d/b/a Donna DiMarco Nutrition Counseling program of nutrition, evaluation, stress reduction, biofeedback and educational activities at Spring of Life, Inc. (thereafter referred to as "SOL") agree to the following:

That I understand that Donna DiMarco is a licensed nutritionist and her services are restricted to the subjects of diet and nutritional matters, NAET, herbs, vitamins, amino acids, homeopathy and other nutraceuticals intended for the best possible state of health.

That I understand that this is a voluntary, supplemental course of biochemical, nutritional balancing as described above. These methods DO NOT SUBSTITUTE for conventional medical office visits with your primary care doctor or other medical specialists such as gynecologists, urologists or oncologists. Biofeedback/bioenergetic screening does not substitute for conventional, routine medical tests such as X-rays, CAT scans, MRI's, PAP Smear tests or mammograms.

That I hereby consent to make personal records available to SOL employees and consultants for the purpose of: (a) developing a comprehensive health evaluation; (b) future nutritional, stress reduction and educational planning; (c) scientific research.

That I agree to give permission for my medical records to be released to SOL if necessary and I do or do not give SOL permission to contact my doctor for either copies of my test reports or permission to implement a nutritional program.

My primary care physician is: Dr. _____

Address _____

City _____ State _____ Zip _____ Phone _____ - _____

That SOL, its officers, employees, consultants and/or agents have made no guarantee of any kind.

That I have been advised against increasing any physical activities beyond customary levels.

That I have been advised against changing or eliminating any medication or medical regimen without first consulting my physician.

That I have correctly listed whether I am presently under a medical doctor or physician's care, listed all medications, and have or will obtain written consent from said healthcare practitioner permitting me to participate in a nutritional program at SOL.

That I am completely responsible for my own health and wellbeing at all times and SOL, its officers, employees, consultants and/or agents act simply as advisors in my quest for better/more optimal health.

That I hereby consent to participate in the program and release SOL, its officers, employees, consultants and/or agents from any liability or claims from accidents, injury or claims by me.

That I also agree to indemnify and to hold SOL, its officers, employees, consultants and/or agents harmless from any and all liability claims resulting from any accidents, injury or otherwise, that might occur in any manner in connection with the program.

Name Printed _____

Signature _____ Dated _____

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Date _____ Referred By _____

Name _____ Age _____ Birthday _____

Address _____ Apt _____

City _____ State _____ Zip _____

Home Phone _____ - _____ Business Phone _____ - _____ Cell _____ - _____

Height _____ Weight _____ Blood Type _____ E-Mail _____

Chief Complaint _____

List Previous Surgeries _____ When _____

_____ When _____

_____ When _____

_____ When _____

List know allergies and sensitivities: _____

Please Fill in Medication List on attached sheet Done

Are you presently under the care of a medical doctor, chiropractor or other health care provider? Yes No

Does your health care provider know you are seeking the advice of a nutrition counselor? Yes No

Will he/she give written consent to see a nutrition counselor? Yes No

Consent Received from: _____ Degree _____ Date _____

Other pertinent Information:
