8685 W. Union Hills Drive, Peoria, AZ 85382
Phone: 623.486.2331 Fax: 623.486.3136
2525 W. Carefree Highway, Bldg. 5 #136, Phoenix, AZ 85085
Phone: 623.580.0111 Fax: 623.580.9080
ArrowheadPT.com

Case #: ___________________

Date: _____________________ Revised 8/24/17

Nutrition Intake Form

Patient Name ______________________________ DOB ________________

Home Address ______________________________ City ____________ State ________ Zip ________

Home Phone ______________________________ Cell Phone ______________________

Email Address ____

Emergency Contact Information

Name of person to contact ________________________ Relationship ______________________

Address ______________________________ Phone ______________________

Health & Nutrition Liability Waiver/Informed Consent Form

"I have enrolled in a nutrition program offered through Arrowhead Physical Therapy. I recognize that the program may involve nutrition recommendations including, but not limited to, nutrient suggestions, meal preparation coaching, lifestyle coaching, and BIA (bio-impendance analysis) testing. I hereby affirm that I am in good physical condition and do not suffer from any known disability or condition which would prevent or limit my participation in a nutrition program. I acknowledge that my enrollment and subsequent participation is purely voluntary and in no way mandated by Arrowhead Physical Therapy. I acknowledge that my primary health care provider has agreed to my participation in this nutrition program."

"In consideration of my participation in this program, I hereby release Arrowhead Physical Therapy and its agents from any claims, demands, and causes of action as a result of my voluntary participation and enrollment."

"I fully understand that I may experience changes in my body composition as a result of my enrollment and subsequent participation in this program and I hereby release Arrowhead Physical Therapy and its agents from any liability now or in the future for conditions that I may obtain. These conditions may include, but are not limited to, headaches, changes in my gastrointestinal function, nausea, changes in sleep patterns, or other unknown side effects. Should these occur, I agree to report symptoms to the nutrition specialist and my primary health care provider. Before taking any suggested nutritional supplements or medical foods I agree to first consult with my primary health care provider."

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

Client Name (Please Print): ______________________________ *Date:* ______________________

Signature of Client or Legal Representative: ____

Relationship to Client: ____