

NAPCC

CONFIDENTIAL INFORMATION / AUTHORIZATION FORM

Patient Name: _____ City: _____

Street: _____ Postal/Zip Code _____

Telephone # _____ D.O.B. ____ / ____ / ____ Age: ____ Sex: Female Male
day mo year

Referred By: _____ Blood Type A AB B O

Family Doctor or Specialist _____ Telephone # _____

Date of Cancer Diagnosis _____ Type of Cancer _____

Current Treatments _____

Have you been diagnosed with any other condition/disease? _____

_____ Date: _____

Servings per week: coffee ____ black tea ____ herbal tea ____ pop ____ alcohol ____ fruit juice ____

Do you currently have a special diet? _____ What is it called? _____

Do you currently take vitamins or supplements? _____ Occasionally? _____ Daily? _____

List Them Here _____

How Much Water do you drink on average during a normal 24 hr period _____ ounce(s)

Have you had any physical or exercise restrictions placed on you by your doctor? _____

If yes, Please explain: _____

PRESCRIPTION DRUGS AND OVER THE COUNTER MEDICATIONS

If you take any medications at all please name them and the condition they support

Drug Name: _____ Taken for: _____

Drug Name: _____ Taken for: _____

Drug Name: _____ Taken for: _____

Drug Name: _____ Taken for: _____

I fully understand that the information I receive is not for medical advice or diagnosis. If I am on prescription medication and if I choose to follow the program, dietary recommendations and/or lifestyle changes as recommended by the NAPCC Coach, then I shall advise my medical doctor so that he /she may supervise my care and reduce or eliminate my need for these medications as he/she finds necessary. This authorization shall be valid for the entire duration of my care.

Signed this _____ day of _____ 2010 _____

Signature