Nutrition Moves! Geri Lynn Grossan, RD, MEd, CDE, HTP

New Client Questionnaire and Three-Day Record

Name_____ Date_____

Address_____ Phone _____

City _____ State _____ Zip Code _____

Email _____ Occupation_____

Marital Status ___ M ___ D ___ W ___S _____

Height_____ Weight _____ Age _____ Sex: _____

Desired Weight_____ Last time you weighed desired weight _____

Have you tried to lose weight before? ( ) Yes ( ) No If Yes, when?_____

Diet (specify)_____ Weight Change_____ How long did it last?_____

Weight History:

Childhood	___Underweight	___ Normal	___ Overweight	___ Obese
Teenage	___Underweight	___ Normal	___ Overweight	___ Obese
20‘s	___Underweight	___ Normal	___ Overweight	___ Obese
30‘s	___Underweight	___ Normal	___ Overweight	___ Obese
40‘s	___Underweight	___ Normal	___ Overweight	___ Obese
50’s	___Underweight	___ Normal	___ Overweight	___ Obese
60’s +	___Underweight	___ Normal	___ Overweight	___ Obese

Family Weight History:

Mother	___Underweight	___ Normal	___ Overweight	___ Obese
Father	___Underweight	___ Normal	___ Overweight	___ Obese
Sibling 1	___Underweight	___ Normal	___ Overweight	___ Obese
Sibling 2	___Underweight	___ Normal	___ Overweight	___ Obese

Elimination Habits ___ More than 1 time per Day ___ Daily ___ Less than Daily

Have you ever used laxatives for weight control? ( ) Yes ( ) No

Have you ever purged for weight control? ( ) Yes ( ) No

Do you have any food allergies/Intolerances? ( ) Yes ( ) No
If Yes, Specify:_____

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Medical History: (list chronic illnesses, surgeries, major hospitalizations)_____

_____

_____

_____

Current Medications: _____

_____

Do you take any vitamin, mineral or food supplements? ( ) Yes ( ) No
If Yes, List_____

_____

Have you been advised by your physician to follow a type of diet? ( ) Yes ( ) No
If Yes, Type of Diet: ___ No Salt ___ Low Cholesterol ___ No Sugar _____Other

Blood Work Values: (provide copies of recent blood work if available)

____Glucose ____ HgbA1C ____Cholesterol ____ HDL ____LDL ____ Triglycerides

Other pertinent values _____

Are your menstrual periods regular? ( ) Yes ( ) No ( ) NA

Do you exercise? ( ) Yes ( ) No
If Yes, Type/duration_____

Describe what you do to relax _____

***** The following are questions about your typical eating patterns *****

How many days per week do you eat? (Breakfast)_____ (Lunch)_____(Dinner)_____

How often do you snack? ( ) once daily ( ) twice daily ( ) three or more times daily

When do you usually snack? ( ) mid-morning ( ) mid-day ( ) after dinner

Do you eat out? ( ) Yes ( ) No If Yes, How often?_____

Type of restaurants?_____

Do you drink alcohol? ( ) Yes ( ) No # of drinks/week ____

Do you eat standing up? ( ) Yes ( ) No ( ) Occasionally

Do you eat at a table? ( ) Yes ( ) No ( ) Occasionally

Do you eat alone? ( ) Yes ( ) No ( ) Occasionally

Do you eat in the car? ( ) Yes ( ) No ( ) Occasionally

Do you feel you eat fast? ( ) Yes ( ) No ( ) Occasionally

Do you think you are an emotional eater? ( ) Yes ( ) No ( ) Occasionally

Do you engage in other activities when you eat? ( ) Yes ( ) No
If Yes, what activities?_____

Are you responsible for grocery shopping ( ) Yes ( ) No
If No, Who usually does the grocery shopping? _____

Do you read labels? ( ) Yes ( ) No
If Yes, What do you look for on labels?_____

Do you prepare the food you eat? ( ) Yes ( ) No
If No, Who usually prepares the food at home? _____

Is there any member of your household on a special diet? ( ) Yes ( ) No
If Yes, What special diet?_____

What are your favorite foods?_____

_____

Would you like to change your eating habits? ( ) Yes ( ) No
If yes, Please explain why?_____

_____

What are your goals for the initial nutrition consultation?_____

_____

_____

_____

Food Frequency Check List

	Never	Less than 1 time per week	2-3 times per week	4-6 times per week	More than once a day
Lean beef					
High fat beef					
Sausage, bacon					
Lunchmeat-turkey, chicken					
Lunchmeat - bologna, salami					
Pork					
Poultry					
Poultry-prebread-ed (nuggets)					
Poultry-fried					
Fish					
Fish-prebreaded (nuggets)					
Fish –fried					
Shellfish					
Beans, lentils, legumes					
Peanut butter					
Pizza					
Milk (type)					
Cream					
Cheese					
Cheese-Regular					
Cheese-Low Fat					
Cheese Non-fat					
Yogurt					
Ice cream					
Frozen Yogurt					
Eggs					
Oils					
Butter					
Margarine					
Vegetables					
Salads					
Fruits					

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	Never	Less than one time per week	2-3 times per week	4-6 times per week	More Than Once A Day
Fruit Juice					
Breads					
Cereals					
Pasta, noodles, rice					
Potatoes					
Commercial baked goods (cakes, pies, pastries, muffins)					
Cookies-Regular					
Cookies- Low Fat					
Cookies-Fat Free					
Soft drinks-Regular					
Soft drinks-Diet					
Snack crackers					
Nuts and Seeds					
Potato chips or Corn chips					
Sherbets and Ices					
Candy					
Frozen Meals					
Chinese food					
Fast food					
Substitute foods (Soy products, Boca burg-ers)					
List other foods you eat not mentioned:					

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Please Follow Instructions Carefully In Completing This Three-Day Record

1. Write down everything you eat and drink and all vitamin and mineral supplements taken for three (3) days.

2. Measure and record the amount of food served in portion sizes of level measuring cups, teaspoons, tablespoons, ounces. Include slices or inches. You may use a food scale if you have one.

3. Indicate how the food was prepared such as fried, steamed, baked, raw, etc.

4. List brand names of all food products, for example oatmeal might be "Quick Quaker Oats"

5. Be sure to measure and record all those little extras….gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine etc. Indicate the amounts.

6. Try to include at least one weekend day if possible.

7. Describe how you are feeling in the emotional awareness and physical awareness columns. For example, bored and tired, happy and energetic, sad and lethargic, lonely and achy.

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Date_____

Amount	Meal	Time	Emotional Awareness	Physical Awareness
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Dinner			
	Snack			

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Date_____

Amount	Meal	Time	Emotional Awareness	Physical Awareness
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Dinner			
	Snack			

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Date_____

Amount	Meal	Time	Emotional Awareness	Physical Awareness
	Breakfast			
	Snack			
	Lunch			
	Snack			
	Dinner			
	Snack			

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Additional Comments, Questions or Concerns:

Thank you for taking time to fill out this questionnaire.
Please bring it with you to the initial nutrition consultation appointment.
I look forward to helping you reach your nutrition and health goals.

Yours in Good Health,

Geri Lynn

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Client Name (print): _____ Date_____

CONSENT FORM

Philosophy: Welcome to Nutrition Moves! Please read this consent form carefully and if you agree to all of your rights and responsibilities, please sign at the bottom. Please feel free to ask any questions for clarifications at the time of your appointment.

My professional goal is to encourage clients to become knowledgeable about and responsible for their own health, and to help them to reach an optimal level of wellness. Nutritional counseling and/or Healing Touch is designed to improve your health, but is not designed to treat any specific disease or medical condition. Reaching the goal of optimal health and wellness, absent of other non nutritional complicating factors, requires a sincere commitment from you, including lifestyle changes and a positive attitude. I will evaluate your nutritional needs and make recommendations of dietary changes and nutritional supplements as indicated. Since every human being is unique, I cannot guarantee any specific result from my recommendations. I will also recommend Healing Touch if I believe it will help you to achieve your personal health goals.

Healing Touch: I acknowledge and understand that Healing Touch is a gentle, complementary energy based approach to health and healing that can assist my body in its natural ability to heal. I fully acknowledge and understand that this is accomplished through the use of contact and/or non-contact touch. It has been explained to me that Healing Touch is a complementary therapy not intended to replace any currently prescribed medical treatments as ordered by my physicians nor any other medical care that I may be advised to seek by them.

Some of the indications for a Healing Touch session include, but are not limited to:
Supports the body's natural healing process and well-being
Reduction in pain, anxiety, and stress
Decrease in nausea
Preparation for medical treatment and procedures and to manage side effects
Support during chemotherapy
Facilitation of wound healing

Appointments: I agree to make every effort to keep all scheduled appointments and be on time. If I cannot attend a scheduled session, I will call Geri Lynn Grossan, MEd RD CDE HTP/A to cancel and/or reschedule. There will be a full fee of $100 if a phone message or conversation is not received within 24 hours before the scheduled appointment time, to be paid to Geri Lynn Grossan. If I am late the full fee will apply even though I will only be given my allotted time that my appointment was scheduled for. Initial nutrition consultation will generally last 90 minutes and follow up appointments will generally last 60 minutes depending on the visit. Healing Touch sessions will generally last 60-90 minutes.
Confidentiality: I have been informed that all client information and records are treated in a confidential manner. My experiences during these sessions are confidential subject to the usual exceptions governed by state or federal laws and regulations.
Fees and Financial Agreement: Nutrition counseling $100 per hour; Healing Touch $80 per session. Fees for services are due at the time the service is provided. Cancellation policy is outlined above. Forms of payment accepted include cash or check, and Teachers Health Trust insurance.
Counseling Process and Your Rights Regarding Treatment: I understand that Geri Lynn Grossan, MEd RD CDE HTP/A and I will work together to define my goals for nutrition counseling and/or Healing Touch since nutrition counseling and/or Healing Touch is not an exact science, I understand that the results can be variable. I understand that the attainment of a positive outcome is dependent upon the effort expended by both myself and Geri Lynn Grossan and I am willing to put my part into this experience. I understand that I have the right to ask questions about my nutrition counseling and/or Healing Touch. I also have the right to end my services at any time and understand that I should notify Geri Lynn Grossan when I am finished.
Consent for Treatment: I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of Geri Lynn Grossan, MEd RD CDE HTP/A for nutritional counseling and/or Healing Touch. I consent to treatment and I understand that I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time. Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless Geri Lynn Grossan from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Client/Legal Guardian Signature: _____ Date: _____