risa groux CN
nutritionist

Patient Information Form

Welcome to Risa Groux Nutrition CN. Please be complete and accurate. Your answers to the following questions are the first step in determining your immediate and long-term healthcare needs and concerns. Please elaborate on any questions or add any comments you may have…the more we know about your needs and concerns, the better we can serve you. Be assured that your information is held in the utmost of confidentiality. Thank you!

Personal Information

First Name_____LastName_____
StreetAddress_____City_____State___
Zip_____
Home Phone_____Cell Phone_____
Email_____Referred by_____
DOB_____Sex_____
Marital status: S M W D Number of children_____
Occupation_____

Health Information

What is your main health concern?_____

How long have you been experiencing this discomfort?_____Are you:_____Worse_____Better_____ No change_____
Do you have any allergies? _____No Yes_____ Medications?
_____
Foods:_____
Other:_____

Do you have or have had any of the following: (please circle)
Stomach Disorder Stomach Stapled Heart disease
Hernia High blood pressure Cancer High cholesterol/triglycerides
Heartburn Diabetes Thyroid disorder Hepatitis Aids Tuberculosis Herpes
Venereal Diseases Herpes Other_____
What other health or medical challenges/diagnosis do you have:_____

Do you still have the following organs/glands? (Circle if removed)
Gallbladder Uterus Ovaries appendix thyroid tonsils
Any other body part removed: _____

Have you had any surgeries or serious illness:
_____

Have you had any of the following diseases: (circle all that apply)
Anemia Rheumatic Fever Epilepsy Influenza Mental Disorder Mumps
Pleurisy Measles Appendicitis Pneumonia Whooping Cough Polio
Chicken Pox

Have you been under the care of a medical doctor? If so whom and for what condition?
_____
_____

On a scale from 1-10 how interested are you in reaching your bodies maximum health potential? (Please circle)

Not very 1 2 3 4 5 6 7 8 9 10 **Very**

Family History
Please indicate if there have Diabetes, Kidney, Cancer, Thyroid or other health problems:
Father_____
Mother_____
Siblings_____

I have reviewed the information indicated on this questionnaire and its accurate to the best of my knowledge. I understand that this information will be used to determine appropriate and healthful support. If there is a change in my medical status, I will inform my treating physician.

Signature_____**Date**_____

Incase of emergency, whom should we notify:
_____
Relationship_____ **Phone number**_____
Address_____