Patient Information Form

Welcome to Risa Groux Nutrition. When filling out this form please be complete and as accurate as possible. Your answers to the following questions are the first step in determining your immediate and long-term health 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 strictest confidentiality. Thank you!

Personal Information

First Name______________________ Last Name____

Street Address _________________________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 are your main health concerns?____

____

____

____

How long have you been experiencing this discomfort?____

Are you: __________ Worse _________ Better __________ No change

Do you have any allergies?____ No ____Yes

Foods: ____

Other: ____

Do you have stomach bloating? _____Yes_____No Acid Reflux___ Yes___No Heartburn____Yes____No

Do you have or have had any of the following? (please circle)

Stomach Disorder Stomach Stapled Heart disease Hernia Ulcer High blood pressure Cancer High cholesterol/triglycerides Epstein Barr Virus Mononucleosis Heartburn Acid Reflux Diabetes Thyroid disorder Hepatitis AIDS Tuberculosis Herpes Venereal Diseases Other _

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 Shingles

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, autoimmune, 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** ______________

In case of emergency, whom should we notify: ______________________

Relationship______________ Phone number______________________

Address____