risa groux cn

holistic nutritionist

Substance Survey Form

Name_____Date_____

Please list any **PRESCRIPTION MEDICATIONS** you are currently taking or have taken in the last 2 years:

Name	Daily Dosage	Diagnosis or Symptom	Dates of Use

Please list any **OVER THE COUNTER MEDICATIONS** you are currently taking or have taken in the last 2 years:

Name	Daily Dosage	Diagnosis or Symptom	Dates of Use

Please list any **VITAMINS, SUPPLEMENTS OR HERBS** you are currently taking or have taken in the last 2 years:

Name	Daily Dosage	Diagnosis or Symptom	Dates of Use

Please list all **SURGERIES** or **MEDICAL PROCEDURES:**

Circle the following items that apply to you and indicate the amount used

Candy _____ Ice Cream _____ Soda _____ Artificial Sweetener _____ Laxative _____ Antacids _____

How many desserts do you average in a week? _____