risa groux cn

holistic
nutritionist

20311 SW Birch Street
Suite 150
Newport Beach, CA 92660

Attached is the paperwork you will need for your first visit with Risa Groux, CN. Your appointment has been scheduled under the assumption that your paperwork will have been completed prior to your appointment time. When filling out the system survey form, please follow the directions carefully. Mark "1" in the box for mild symptoms, "2" for moderate symptoms or "3" for severe symptoms. If the symptom does not apply to you, leave the box blank. Please have all of the forms completed before you come in for your appointment so she can spend the entire time allotted for you.

When you arrive for your appointment please bring the following:

~Completed new patient forms
~Completed System Survey form
~Summary of your medical history
~Current blood test results
~Vitamin or supplements you are currently taking

Your initial consultation will be $250, which includes the initial 1 hour visit to go through all your information, discuss your health goals, and do non-invasive nutrient deficiency testing. The 2nd visit we will review the report of findings and discuss the suggested plan moving forward. Subsequent visits are $85 unless you decide to take advantage of discounted package pricing. Please allow 1 hour for the initial consultation and 30 minutes for subsequent visits. I look forward to working with you to establish vital health in your life. If you have any questions, please call me at (949) 851-3106.

I look forward to helping you achieve your health goals!

Risa Groux CN
Holistic Nutritionist

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Daily Food Log

Please list all food and beverages you consume for the entire day with approximate times and quantity

Date: _____

Breakfast: _____ Time: _____

Snack: _____ Time: _____

Lunch: _____ Time: _____

Snack: _____ Time: _____

Dinner: _____ Time: _____

Date: _____

Breakfast: _____ Time: _____

Snack: _____ Time: _____

Lunch: _____ Time: _____

Snack: _____ Time: _____

Dinner: _____ Time: _____

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Office Policies and Consent to Treatment

Welcome! I look forward to working with you in holistic nutrition. I believe your commitment to the health and wellness process will provide you positive changes throughout your life. I do want you to know that this is not a diet center, I teach you how to fuel your body for optimum health through eating whole foods and supplementation.

CONFIDENTIALITY: All information disclosed within sessions is confidential which means I will not disclose any information (including whether or not you are my client/patient) to anyone without your prior permission.

PAYMENT FOR SERVICES: Patients are expected to pay in full for services when signing up for a package after initial nutritional consultation. We accept cash, credit card or checks. All packages expire six months after the purchase date. Packages are nonrefundable and nontransferable. If paying for individual consultation, payment is due at the time of service.

VACATION POLICY: I travel for personal and professional reasons. When I am out of the office I will typically leave my assistant in charge or can be reached by email if necessary. I will inform you of these dates as they come about.

CANCELLATION POLICY: When we reserve an appointment, I reserve this time specifically for you. We require a minimum of **24 hours** when canceling appointments. It is our duty to set standards such as these to protect our time invested in you as the patient. A no show fee will be given at $40 for missing appointments without notification or without reasoning within a prior 24 hour period before appointment.

I have read and understand the cancellation policy. I have provided a credit card to keep in my file and understand it will ONLY be charged after a missed appointment if not enough notice is given within 24 hours.

I consent to regular appointments and treatment, and have read and understand the above policies.

Signature:_____ Date:_____

Print name:_____

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT_____ AGE_____ DOCTOR_____ DATE_____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank**.
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 "Nervous" stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 "Butterfly" stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels "lightheaded" often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels "irregular"
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 "Slow starter"
38 – 1 2 3 Get "chilled" infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get "shaky" if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 "Lightheaded" if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - "blues" or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, "air hunger"
58 – 1 2 3 Aware of "breathing heavily"
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon "yawner"
63 – 1 2 3 Get "drowsy" often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, "black and blue" spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 "Nose bleeds" frequent
71 – 1 2 3 Noises in head, or "ringing in ears"
72 – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP FIVE

73 – 1 2 3 Dizziness
74 – 1 2 3 Dry skin
75 – 1 2 3 Burning feet
76 – 1 2 3 Blurred vision
77 – 1 2 3 Itching skin and feet
78 – 1 2 3 Excessive falling hair
79 – 1 2 3 Frequent skin rashes
80 – 1 2 3 Bitter, metallic taste in mouth in mornings
81 – 1 2 3 Bowel movements painful or difficult
82 – 1 2 3 Worrier, feels insecure
83 – 1 2 3 Feeling queasy; headache over eyes
84 – 1 2 3 Greasy foods upset
85 – 1 2 3 Stools light-colored
86 – 1 2 3 Skin peels on foot soles
87 – 1 2 3 Pain between shoulder blades
88 – 1 2 3 Use laxatives
89 – 1 2 3 Stools alternate from soft to watery
90 – 1 2 3 History of gallbladder attacks or gallstones
91 – 1 2 3 Sneezing attacks
92 – 1 2 3 Dreaming, nightmare type bad dreams
93 – 1 2 3 Bad breath (halitosis)
94 – 1 2 3 Milk products cause distress
95 – 1 2 3 Sensitive to hot weather
96 – 1 2 3 Burning or itching anus
97 – 1 2 3 Crave sweets

GROUP SIX

98 – 1 2 3 Loss of taste for meat
99 – 1 2 3 Lower bowel gas several hours after eating
100 – 1 2 3 Burning stomach sensations, eating relieves
101 – 1 2 3 Coated tongue
102 – 1 2 3 Pass large amounts of foul-smelling gas
103 – 1 2 3 Indigestion 1/2 - 1 hour after
104 – 1 2 3 Mucous colitis or "irritable bowel"
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can't gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can't work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
130 – 1 2 3 Mental sluggishness
131 – 1 2 3 Hair coarse, falls out
132 – 1 2 3 Headaches upon arising wear off during day
133 – 1 2 3 Slow pulse, below 65
134 – 1 2 3 Frequency of urination
135 – 1 2 3 Impaired hearing
136 – 1 2 3 Reduced initiative

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, "splitting or rendering" type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Apprehension
174 – 1 2 3 Irritability
175 – 1 2 3 Morbid fears
176 – 1 2 3 Never seems to get well
177 – 1 2 3 Forgetfulness
178 – 1 2 3 Indigestion
179 – 1 2 3 Poor appetite
180 – 1 2 3 Craving for sweets
181 – 1 2 3 Muscular soreness
182 – 1 2 3 Depression; feelings of dread
183 – 1 2 3 Noise sensitivity
184 – 1 2 3 Acoustic hallucinations
185 – 1 2 3 Tendency to cry without reason
186 – 1 2 3 Hair is coarse and/or thinning
187 – 1 2 3 Weakness
188 – 1 2 3 Fatigue
189 – 1 2 3 Skin sensitive to touch
190 – 1 2 3 Tendency toward hives
191 – 1 2 3 Nervousness
192 – 1 2 3 Headache
193 – 1 2 3 Insomnia
194 – 1 2 3 Anxiety
195 – 1 2 3 Anorexia
196 – 1 2 3 Inability to concentrate; confusion
197 – 1 2 3 Frequent stuffy nose; sinus infections
198 – 1 2 3 Allergy to some foods
199 – 1 2 3 Loose joints

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month
FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.
MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date:_____ Temperature: _____
Date:_____ Temperature: _____
Date:_____ Temperature: _____
Date:_____ Temperature: _____
Date:_____ Temperature: _____
Date:_____ Temperature: _____
Date:_____ Temperature: _____

BP SIT _____ BP STAND _____
PULSE SIT _____ PULSE STAND _____
SALIVA PH _____ BLOOD TYPE _____

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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? _____

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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_____