risa groux cn

functional nutritionist

20162 SW Birch Street, Suite 280
Newport Beach, CA 92660
(949)851-3106

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 Metabolic Assessment form, please follow the directions carefully. Mark "0" in the box for no symptoms, "1" for mild symptoms, "2" for moderate symptoms or "3" for severe symptoms. 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 Metabolic Assessment form
~Most recent blood test results
~Vitamin or supplements you are currently taking or a photo of them front and back

Your initial consultation will be $275, which includes the initial 1 hour visit to go through all your information, discuss your health goals, and do non-invasive nutrient deficiency testing. There may be a 2nd visit (no additional charge) in which we will review the report of findings and discuss the suggested plan moving forward. Subsequent visits are $95 unless you decide to take advantage of discounted package pricing. Please allow 1 hour for the initial consultation and 30 minutes for subsequent visits. We look forward to working with you while looking for root causes and optimizing your health. If you have any questions, please call us at (949) 851-3106.

We look forward to helping you achieve your health goals!

The office of Risa Groux CN
Functional Nutritionist

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? (Circle if removed)
Gallbladder Uterus Ovaries Appendix Thyroid Tonsils

Any other body part removed: _____
Have you had any serious illness? _____
Have you had any of the following diseases? (Circle all that apply)
Anemia Rheumatic fever Epilepsy Influenza Mental Disorder Mumps Shingles
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 they 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 we should notify: _____

Relationship: _____ Phone number: _____

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Patient Questionnaire

Sleep:

What hour do you typically go to sleep? _____

What hour do you typically wake up? _____

Do you wake in the middle of the night? ___ Y ___ N

If so, what time? _____

How do you feel before bedtime? (Circle one)

Ready for bed Wired & tired Exhausted Not tired at all

How do you feel when you wake up in the morning? (Circle one)

Ready to go Slow starter Exhausted

Exercise:

Do you exercise? _____

If so, what type? _____

Time spent exercising weekly: _____

Consumption Habits:

Indicate the amount used weekly of the following:

Candy	Ice cream	Soda	Artificial sweetener	Laxative	Antacids	Tea	Juice (green or other)	Water (daily ounces)

Coffee:

What do you put in it? _____

Weekly consumption: _____

Alcohol:

what type _____

Weekly consumption: _____

How many desserts do you average in a week? _____

Do you crave sugar? ___ Y ___ N

Do you crave salt? ___ Y ___ N

Do you smoke anything of any kind? ___ Y ___ N
If so, what kind and how much? _____

Bowel Movements:

Number of daily bowel movements: _____
Are they formed, soft, liquid, long, or pellets? _____
Do they leave marks on the bowl (like you need to double flush)? _____
Do they sink or do they float? _____
Is there mucus or blood in your stool? _____
If so, how often? _____

Other:

Do you take birth control? ___ Y ___ N
Do you take hormone replacement therapy (HRT)? ___ Y ___ N
Are you menstruating? ___ Y ___ N
If so, are you regular? _____

Do you get headaches? ___ Y ___ N
Does your hair fall out excessively in the shower? ___ Y ___ N

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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 all **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

List all **NSAIDs** used (Tylenol, Advil, Aleve, etc.):

Name	Daily Dosage	Diagnosis or Symptom	Dates of Use

Please list all **SURGERIES** or **MEDICAL PRODEDURES**: _____

_____

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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:	Time:
Breakfast:	
Snack:	
Lunch:	
Snack:	
Dinner:	
After Dinner:	

Date:	Time:
Breakfast:	
Snack:	
Lunch:	
Snack:	
Dinner:	
After Dinner:	

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3

Have you had your gallbladder removed? **Yes** **No**

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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Office Policies and Consent to Treatment

Welcome! I look forward to working with you in functional 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 $50 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:_____