Nutrition Solutions, LLC
Cancellation Policies

Thank you for choosing ***Nutrition Solutions***. Our mission is to educate, inspire and guide you to better health and wellness with balanced nutrition. Due to high demand for appointments we've had to implement a strict cancellation policy. We recommend that you keep your desired appointments, as they are difficult to obtain.

- 48 hours notice is required to cancel or reschedule any appointment.
- Without 48 hours notice on an initial visit, there will be a charge of $50.00.
- Without 48 hours notice on any follow up visits, there will be a charge of $35.00.
- No refunds will be given for nutrition package programs purchased.

Thank you very much for your cooperation.

These Policies have been implemented to help keep appointments, which aid in your success

Please bring this form to your initial nutrition assessment!

3 Day Diet Recall

Please include 2 week days & 1 weekend day, include all beverages & list the amount/portion size you are eating.

Day 1	Day 2	Day 3
Breakfast	**Breakfast**	**Breakfast**
Snack	**Snack**	**Snack**
Lunch	**Lunch**	**Lunch**
Snack	**Snack**	**Snack**
Dinner	**Dinner**	**Dinner**
Snack	**Snack**	**Snack**

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CHILD/TEEN HEALTH HISTORY QUESTIONNAIRE
PREFERABLY FILLED OUT BY THE CHILD WITH PARENTAL ASSISTANCE

Personal Information

Name _____

Address _____

_____

Parent's Names:_____

Phone # _____

DOB ___ / ___ / _____ Age _____ Gender: ☐ M ☐ F

Ethnicity _____

Grade:_____

Brothers:_____Sisters:_____

SCHOOL: _____

Physician Information

Please provide physician information below. According to the American College of Sports Medicine, it may be necessary to receive physician clearance prior to starting your weight loss and exercise program.

Name _____

Address _____

_____

Phone # _____

Section #1

Height: _____ Weight: _____

Section #2

DO YOU EAT MORE THAN YOU WOULD LIKE TO WHEN YOU FEEL SAD, ANGRY, OR LONELY?

1. Never 3. Occasionally
2. Rarely 4. Frequently 5. Always

Are there any foods that often cause you to overeat?

☐ Yes ☐ No

If *YES*, please list: _____

Are you presently undergoing any changes in your life? (e.g., parents divorce, moving or recently moved, new school, trouble with friends?)

☐ Yes ☐ No

If *YES*, please list: _____

_____

_____

Section #3

How did you hear of Nutrition Solutions?

_____

What are your goals: *(Please indicate all that apply)*

☐ Lose weight ☐ Feel better overall

☐ Learn about dining out

☐ Learn about nutrition ☐ Improve fitness level

☐ Other (please specify): _____

Section #4

Are you presently exercising a minimum of three times per week at least 30 minutes at a time?

☐ Yes ☐ No

If *YES*, please specify:

☐ Running/jogging ☐ Brisk walking ☐ Biking

☐ Dancing ☐ Soccer ☐ Swimming

☐ Football ☐ Field Hocky ☐ Wrestling

☐ Other *(please specify):* _____

Total hours engaged in TV watching, computer use or video games *per day*:

☐ 0-2 hrs/day

☐ 2-4 hrs/day

☐ 4-6 hrs/day

☐ 6+ hrs/day

If any, which do you enjoy the most?

_____

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Section #5

CHECK ALL THAT APPLY.

- ☐ Last doctors office visit greater than 1 year ago
- ☐ Congenital heart disease
- ☐ Diagnosed uncontrolled hypertension (above 140/90)
- ☐ Experience frequent light headedness or fainting
- ☐ Epilepsy or seizures
- ☐ Head trauma
- ☐ Infectious mononucleosis (current)
- ☐ Physician currently restricting activity level
- ☐ SLEEP APNEA
- ☐ SHORTNESS OF BREATH WHILE PERFORMING NORMAL ACTIVITIES
- ☐ Bone or joint condition aggravated by activity
- ☐ Eating disorder
- ☐ Hernia
- ☐ Cancer
- ☐ Current physical therapy (within past 3 months)
- ☐ Diabetes
- ☐ Kidney disease

** If you marked any statements in Section #5, consult your healthcare provider before engaging in exercise.*

SECTION #6

Check all that apply.

- ☐ Currently taking blood pressure medication
- ☐ Heart murmur
- ☐ Diagnosed hypercholesterolemia (above 240mg/dl)
- ☐ Asthma
- ☐ Foot problems
- ☐ Knee problems
- ☐ Back problems
- ☐ Shoulder problems
- ☐ Current smoker
- ☐ Do not currently exercise

** If you marked two or more statements in Section #6, consult your healthcare provider before engaging in exercise.*

Which of the following apply to your immediate family?

- ☐ Heart attack / cardiac related surgery prior to 50 years of age
- ☐ Strokes prior to 50 years of age
- ☐ Parent(s) with Diabetes
- ☐ Grandparent(s) with Diabetes
- ☐ Parent(s) with high blood pressure
- ☐ Parent(s) with high cholesterol
- ☐ Obesity

SECTION #7

CHECK ALL THAT APPLY.

- ☐ Rheumatic fever
- ☐ Diagnosed controlled hypertension
- ☐ Don't know cholesterol
- ☐ Migraine/headaches
- ☐ Anemia
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Hyperthyroid / hypothyroid disorder
- ☐ Increased anxiety
- ☐ Depression
- ☐ Unusual fatigue
- ☐ Broken bones
- ☐ Ulcer
- ☐ Stomach or intestinal problems
- ☐ Acid reflux/Heartburn

Are you currently being treated for any other medical condition(s)?

☐ Yes ☐ No

If *YES*, please list:

SECTION #8

Please list any medications you are currently taking and the reason.

_____

_____

_____

_____

_____

_____

Please list any vitamins / herbal supplements you are currently taking.

_____

_____

_____

Do you actively participate in gym class?

☐ Yes ☐ No

If *No*, why not? _____

_____

Health Professional: _____ *Date:* _____

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HEALTH HISTORY QUESTIONNAIRE

Personal Information

Name _____

Address _____

_____

Phone # _____ (Cell) _____

Social Security # _____

Email_____

DOB ___ / ___ / _____ Age _____ Gender: ☐ M ☐ F

Marital status: ☐ M ☐ S ☐ D ☐ W Ethnicity _____

Number of children: _____

Employment status: ☐ Fulltime ☐ Part-time ☐ Retired ☐ Disability

OCCUPATION: _____

Place of Employment:_____

Physician Information

Name _____

Address _____

_____

Phone # _____

Height: _____ **Weight:** _____

Usual Weight:_____ **Goal Weight:**_____

Reason for Appointment:_____

_____

How did you hear of Nutrition Solutions?

_____

What are your goals: *(Please indicate all that apply)*

☐ Lose weight ☐ Improve muscle conditioning

☐ Improve nutrition ☐ Reduce stress

☐ Lower cholesterol ☐ Improved health

☐ Improve cardio. fitness ☐ Feel better overall

☐ Other (please specify): _____

Have you ever been advised by your physician to follow a special diet? ☐ Yes ☐ No

IF YES, PLEASE SPECIFY:_____

Are you currently following that diet?

☐ Yes ☐ No

If Applicable:

Have you tried other weight loss programs in the past?

☐ Yes ☐ No

If *YES*, please specify:_____

_____

Compared to previous attempts, how motivated are you to lose weight at this time?

1. Not at all motivated
2. Slightly motivated
3. Somewhat motivated
4. Quite motivated
5. Extremely motivated

How certain are you that you will stay committed to a weight-loss program for the time it will take to reach your goal?

1. Not at all certain
2. Slightly certain
3. Somewhat certain
4. Quite certain
5. Extremely certain

DO YOU EAT MORE THAN YOU WOULD LIKE TO WHEN YOU HAVE NEGATIVE FEELINGS, SUCH AS ANXIETY, DEPRESSION, ANGER, OR LONELINESS?

1. Never
2. Rarely
3. Occasionally
4. Frequently
5. Always

Are there any foods that often cause you to overeat?

☐ Yes ☐ No

If *YES*, please list: _____

_____

Are you presently trying to make any other big changes in your life (e.g., divorce, job change, moving, smoking cessation?)

☐ Yes ☐ No

If *YES*, please list: _____

Check the description that best represents the amount of stress you experience on a daily basis.

☐ No stress

☐ Occasional mild stress

☐ Frequent moderate stress

☐ Frequent high stress

☐ Constant stress

☐ Constant stress

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Family Weight History:

Do you drink alcoholic beverages at all?

☐ Yes ☐ No

If *YES*, please specify the number of drinks *per week*:

☐ 0-2 drinks ☐ 3-14 drinks ☐ More than 14 drinks

NOTE: One drink equals one ounce of hard liquor, 6 oz. of wine, or 12 oz. of beer.

SPECIFY TYPE**:**_____

Are you presently exercising a minimum of three times per week at least 30 minutes at a time?

☐ Yes ☐ No

If *YES*, please specify:

☐ Running/jogging ☐ Brisk walking ☐ Biking

☐ Aerobic dancing ☐ Racquet sports ☐ Swimming

☐ Weight training ☐ Cross country skiing

☐ Other *(please specify):* _____

Total *minutes* engaged in aerobic activity *per week*:

☐ 0-20 min/week ☐ 21-40 min/week ☐ 41-60 min/week

☐61-80 min/week ☐ 81-100 min/week☐ 100+ min/week

Do you belong to a gym? ☐ Yes ☐ No

Do you have any equipment in the home?

☐ Yes ☐ No

If yes, please specify:_____

_____

Have you participated in cardiac rehabilitation or physical therapy in the past 12 months? ☐ Yes ☐ No

If *YES*, for what reason? _____

Family Weight History:

Are any members of your family overweight?

☐ Yes ☐ No

Does your family eat meals together?

☐ Yes ☐ No

Does anyone in your family diet?

☐ Yes ☐ No

If yes, please explain_____

_____

Do any of the following apply to your immediate family?

☐ Heart attack / cardiac related surgery prior to 50 years of age

☐ Strokes prior to 50 years of age

If so, please specify:_____

_____

EATING HABITS:

Who does the grocery shopping?_____

Who usually prepares the food at home?_____

Do you know how to cook? ☐ Yes ☐ No

Do you eat standing up? ☐ Yes ☐ No

Do you eat fast? ☐ Yes ☐ No

Do you eat while watching TV? ☐ Yes ☐ No

Do you eat while in the car? ☐ Yes ☐ No

Do you avoid certain foods? ☐ Yes ☐ No

If yes, please specify_____

_____

_

What are your expectations from coming to see the dietitian today?

_____

_____

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CHECK ALL THAT APPLY.

- ☐ Last physician office visit greater than 1 year ago
- ☐ Congenital heart disease
- ☐ Heart failure
- ☐ Heart disease
- ☐ Palpitations or tachycardia
- ☐ Pacemaker or IACD
- ☐ Heart attack
- ☐ Bypass or other cardiac surgery / procedures
- ☐ Currently taking medication for heart condition
- ☐ Chest discomfort with or without activity
- ☐ Diagnosed uncontrolled hypertension (above 140/90)
- ☐ Experience frequent light headedness or fainting
- ☐ Epilepsy or seizures
- ☐ Head trauma
- ☐ SLEEP APNEA
- ☐ SHORTNESS OF BREATH WHILE PERFORMING NORMAL ACTIVITIES
- ☐ Bone or joint condition aggravated by activity
- ☐ Currently pregnant or less than six weeks post-partum
- ☐ Eating disorder
- ☐ Hernia
- ☐ Cancer or lymphedema
- ☐ Stroke
- ☐ Current physical therapy (within past 3 months)
- ☐ Diabetes
- ☐ Impaired glucose tolerance
- ☐ Kidney disease
- ☐ Infectious mononucleosis (current)
- ☐ Physician currently restricting activity level

Female over 55

- ☐ Male over 45
- ☐ Currently taking blood pressure medication
- ☐ Heart murmur
- ☐ Diagnosed hypercholesterolemia (above 240mg/dl)
- ☐ Emphysema
- ☐ Asthma
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Foot problems
- ☐ Knee problems
- ☐ Back problems
- ☐ Shoulder problems
- ☐ Current smoker
- ☐ Do not currently exercise
- ☐ Currently 20 pounds over ideal weight

CHECK ALL THAT APPLY.

- ☐ Rheumatic fever
- ☐ Poor circulation
- ☐ Diagnosed controlled hypertension
- ☐ Low blood pressure
- ☐ Don't know resting blood pressure
- ☐ Don't know cholesterol
- ☐ Migraine/headaches
- ☐ Anemia
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Hyperthyroid / hypothyroid disorder
- ☐ Menopause
- ☐ Fibromyalgia
- ☐ Increased anxiety
- ☐ Depression
- ☐ Unusual fatigue
- ☐ Swollen or stiff joints
- ☐ Bursitis
- ☐ Broken bones
- ☐ Osteopenia
- ☐ Ulcer
- ☐ Stomach or intestinal problems
- ☐ Acid reflux
- ☐ Former smoker - quit less than 1 year ago
- ☐ Weight loss surgery

Are you currently being treated for any other medical condition(s)?

☐ Yes ☐ No

If *YES*, please list:

_____

Please list any medications you are currently taking and the reason

_____

_____

_____

Please list any vitamins / herbal supplements you are currently taking.

_____

_____

_____

Please list any allergies, including food allergies:

_____

_____

.

Health Professional: _____ *Date:* _____

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MedGem Protocol

Prior to your appointment in which the MedGem will be performed, the following guidelines MUST be followed for the most accurate testing of your RMR (Resting Metabolic Rate)

If all of the below guidelines are not met, your appointment will have to be rescheduled

- **Please arrive 15 minutes prior to your scheduled appointment-you will need to be in a RESTING state (minimal talking, moving, or fidgeting) prior to the test**

- **Ideal guidelines:**
- **Ideal time to take the test is first thing in the morning after 8-12 hours of NO eating, drinking (water ok), or consuming caffeine, nutritional supplements or medication that contains ephedra, Ma Huang or pseudoephedrine**
- **NO exercise**
- **NO nicotine**
- **If you are taking Meridia, do not take it before the MedGem. You can resume after the test**

- **Acceptable guidelines:**
- **NO eating for at least 4 hours before test (water is OK)**
- **NO exercise for at least 4 hours before test**
- **NO caffeine or stimulatory nutrition supplements or medication that contains ephedra, Ma Huang or pseudoephedrine for at least 4 hours before test**
- **If your are taking Meridia, do not take it before the MedGem. You can resume after the test**
- **No nicotine in any form for at least 1 hour before test**

Thank You!

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