GETTING STARTED INTRODUCTORY FORM

I am interested in:

- ☐ In office consultation Questions regarding my appointment:
- ☐ Phone consultation
- ☐ Skype consultation

I am interested in the:

- ☐ Getting Started Program
- ☐ Getting To Know You Program
- ☐ Keeping You On Track Program
- ☐ Commitment To Succeed Program

Day of the week that works best for me: _____

Time of the day that works best for me: _____

Questions regarding appointment:

NUTRITION QUESTIONNAIRE

Name:		**Date**:	

Address:	
City/State/Zip:	

Phone (Home):		**(work):**		**(cell):**	

Email Address:	

Date of Birth:		**Height:**		**Weight:**	

Reason for consultation:

Goals:

How many times do you usually eat per day?

Describe **3 full typical day's meals, snacks and drinks**, and time of each (please be specific and very complete):

Day 1:

Day 2:

Day 3:

Do you smoke?		Drink alcohol?		How much/when?	
Do you drink caffeine?		What kind?		How much/when?	
Do you overeat?		If so, which foods and how often?			

Do you have any food allergies, restrictions or sensitivities? If yes, please describe.

Describe your daily energy levels:

Do you get noticeably irritable, lightheaded or weak if you haven't eaten in awhile? If yes, please describe.

Do you crave any of the following? (Please X off)

Sugar		Meat		Bread	
Chocolate		Fish		Fat	
Desserts		Milk		Alcohol	
Fried Foods		Pasta		Other	

Which oils do you use/consume? (Please check off)

Butter		Peanut oil		Canola oil	
Margarine		Corn oil		Sun/Safflower oil	
Olive oil		Crisco		Mayonnaise	
Coconut oil		Vegetable oil		Grape seed oil	
Hemp oil		Soybean oil		Flax oil	
Walnut oil		Sesame oil		Other	

How is your dental health?

Do you have problems chewing or swallowing?

Do you eat fast?

Is your eating environment peaceful or stressful?

How much time do you have for meals?

How is your digestion?

How often do you have a bowel movement?

How often do you urinate?

EXERCISE

Do you exercise?

If so, what kind?

How often?

Since when?

Daily Energy Level	Daily Energy Level After Exercise	Daily Stress Level	General Enjoyment of Life
Excellent	Excellent	Very High	Excellent
Good	Good	High	Good
Fair	Fair	Moderate	Fair
Poor	Poor	Low	Poor
		None	

How many hours of sleep do you get on average each night?

Any problems sleeping?

Do you take any nutritional supplements or vitamins?

If so, which ones? Be specific. Attach sheet if necessary.

Please list any prescription or over the counter medications you take on a regular basis. Be specific and list dosages. Attach sheet if necessary.

Family History: Please list any disease, illness, or ailments in your immediate family (i.e. parents,grandparents,siblings).

Rank your skin without lotion: (please circle)

Very dry	Dry	Normal
Oily	Combination	

Symptoms

Please circle any of the following that pertain to you (past or present)

Acne	Cold Sores	Hair Loss	Hypothyroid	Ringing In Ears
Addiction (alcohol & drugs)	Chronic Fatigue	Headaches (frequent)	Hyperthyroid	Seizures
Anemia	Constipation	Headaches (migraine)	Indigestion	Severe Mood Swings
Anorexia	Dandruff	Heart Disease	Insomnia	Skin Conditions
Anxiety	Depression	Heart Burn	Intestinal Problems	Stroke
Arthritis (Osteo)	Diabetes (Type 1)	Hemorrhoids	Kidney Stones	Thyroid Conditions
Arthritis (Rheumatoid)	Diabetes (Type 2)	Herpes Simplex	Liver Problems	Ulcer
Bladder Infections	Diarrhea	High Blood Pressure	Memory Loss or Confusion	Weight (Gain)
Bloating	Emphysema	High Cholesterol	Panic Attacks	Weight (Loss)
Bronchitis	Fainting	HIV	Parasites	Yeast Infections
Cancer	Gall Bladder Problems	Hot Flashes	Pregnant/Nursing	Other:
Colds (frequent)	Gout	Hypoglycemia	Respiratory Problems	Other:

Women: Please circle any that pertain:

PMS
Irregular Periods
Painful Periods
Loss of Periods
Birth Control Pills
Peri-menopause
Loss of Libido
Menopause
Hysterectomy
Children

Men: Please circle any that pertain:

Frequent Urination
Difficulty Urinating
Erectile Dysfunction
Loss of Libido
Prostate Enlargement

Please feel free to expand on any concerns you think are important/relevant to your health.

JACQUELINE JUSTICE, M.S., C.N.S.
Functional Nutritionist
(914) 297-SLIM (7546)

Welcome to my practice. I look forward to working with you in the days ahead. At this time, I would like to acquaint you with the policies that I feel will support the most beneficial use of our time together.

1. A 75 minute appointment is scheduled for your initial visit. During that hour we will spend time going over the enclosed questionnaire, as well as, discussing your lifestyle issues and health goals. You will leave with a preliminary eating plan based on your needs. At your first follow-up appt. (usually scheduled one to two weeks later), you will receive a customized eating plan.
2. **A 24-hour notice of cancellation is requested. If for any reason you are unable to provide that, please remember that it is your reserved time and you are responsible for full payment.**
3. Should a problem arise and I need to cancel our appointment, you will be given a minimum of 24 hours notice.
4. **Please be prompt, as appointments do not extend past the reserved time.**
5. Please see Weight Loss and Wellness Programs for fee information.

Thank you. I look forward to our work together!

I have read the above guidelines and agree to abide by all policies.

Please print:

_____	_____	_____
Name	Signature	Date

CREDIT CARD AUTHORIZATION FORM
FOR PHONE AND SKYPE CONSULTATIONS

I hereby authorize my signature to be on file with Jacqui Justice for the purpose of charging my consultations and product services on my credit card. I authorize the respective credit card company designated below to accept this form in lieu of my signature appearing on the individual credit card receipt for consultations and product services rendered. I am aware that I will receive the receipt, and that this slip will act as my record of this transaction.

I authorize Jacqui Justice to run my credit card the day my appointment has taken place and or when an order has been placed or picked up. (Order example: supplements)

Cancellation and No-Show Policy: No refunds will be issued for not showing up for a previously scheduled appointment or any cancellation made less than 24 hours prior to appointment date. Family and personal emergencies may be exceptions to this rule.

Client Name: _____ Card Type: VISA MASTERCARD AmEx
Credit Card Number: _____
Expiration Date: _____/_____ Security Code: _____
Card Holder Billing Address:
_____
City: _____State: _____ Zip: _____
Phone: _____Cell:_____

_____
Card Holder Name (Print)

_____
Card Holder Signature Date

Please print out, sign and fax completed form to: (914) 961-5016