Jeri Evans Nutrition, Inc. 626.963.6627 jeri@jerievansnutrition.com

Nutrition Questionnaire

PLEASE PRINT USING BLACK OR BLUE INK ONLY

Please circle Yes/No responses or print answers (where applicable)

Administrative Information

Name: _____ Date: _____

How did you learn of our services? _____

Circle: Male or Female Birth Date: ____/_____/_____ Age: _____

Address: _____ City: _____ Zip:_____

Phone: *(to reach you or leave message:)* Day _____/_____/_____ Evening _____/_____/_____

Email: _____

Occupation: _____ Circle: Married or Single #of Children _____

Emergency Contact Name: _____ Phone # _____

Drivers License #: _____ Exp Date: _____

Height: _____ Weight: _____ Ideal weight: _____ Frame size: Small Medium Large (please circle)

Physician or Healthcare Provider Name: _____ Phone # _____

General Health Questions

Medical diagnosis: _____

If you are currently being treated for a specific condition (s) please list: _____

Have you ever had major surgery (include dates): _____

When was your last colonoscopy or sigmoidoscopy? _____

If you had the above procedure what were the results? _____

List medications you are currently taking and what they are for: _____

_____

_____

Please list all supplements you currently take and for what conditions:

_____

_____

_____

What is your Health or Nutrition Goal?

1. _____
2. _____
3. _____

Do you suffer from allergies? Yes or No

List any allergies to medications: _____

_____

List any allergies to food: _____

List any environmental allergies (smog, hay fever):_____

What is your doctor treating you for? _____

Tests (given in the last year)_____

List all Operations: _____

Names of other health professionals you are working with and their specialty: _____

_____

How long has it been since you have felt your best? _____

Will your family or significant other be supportive of you in this program? _____

What is your heritage? (Irish, German, Spanish, etc. _____

Food Sensitivities

Do you react to any of the following? Please check all that apply.

☐ **wheat**	☐ **gluten**	☐ **alcohol**	☐ **soy**
☐ **aloe vera**	☐ **rice**	☐ **potatoes**	☐ **tomatoes**
☐ **milk**	☐ **cheese**	☐ **yogurt**	☐ **honey**
☐ **broccoli**	☐ **barely**	☐ **green drinks**	☐ **agave**
☐ **sweet and low**	☐ **monosodium glutamate**	☐ **meat**	☐ **chicken**

Ability to Detoxify

- How many meals (including snacks) do you eat a day? _____
- Do you frequently skip meals? Yes / No
- If yes, what meal do you skip? _____
- Are you diabetic? Y or N Are you hypoglycemic: Y or N
- Are you anemic? Y or N B 12 deficient? Y or N
- How many bowel movements do you have on an average day? 0 1 2 3 4 5 6 or more
- Do you need to strain? Y or N Do you have odor? Y or N
- Are stools generally; hard, soft, loose, pencil thin, look like bananas, liquid, dark brown, medium brown, light in color, green? Circle answer
- How many ounces do you consume per day? Water: ___ Caffeine: ____ Alcohol: ____
- How many hours do you exercise per week? _____
- Describe exercise? _____
- Do you travel outside the U.S.? Yes / No
- If yes where have you traveled? _____
- Have you ever had any head, neck, back pain or injuries? Yes / No
- If yes, please describe: _____

_____

- Describe any believed exposure(s) to environmental and/or chemical toxins:
  - _____
  - _____
  - _____
  - _____

- What vaccines have you had? _____
- Do you smoke? Y or N If yes, how many times per day?_____

Dental and Airway Questions

- Have you had a root canal? Yes / No
- If yes, how many and when? _____
- Have you had any teeth extracted, including wisdom teeth? Yes / No
- If yes, when? _____
- Do you have a dental bridge in your mouth? Yes / No
- If yes, what materials were used? _____
- Do you have fillings? Yes / No
- If yes, how many and what materials were used? _____

_____

- Do you currently have or have you ever had braces? Yes / No
- Do you use a dental splint? Yes / No
- If yes, what material is used? _____
- Do you have TMJ (jaw problems)? Yes / No

- If yes, please describe: _____
- Do you snore? Yes / No
- Are your teeth sensitive to hot and cold? Yes / No
- Do you have a tooth or gum infection? Yes / No
- Do you have breathing problems or feel you can't breathe deeply? Yes / No
- Do you have sleep apnea? Yes / No
- Are you wearing a sleep appliance or CPAP?
- Do you grind your teeth? Yes / No
- Are you currently getting treatments from a cranial TMJ specialist or Chiropractor?
- Does your dentist use ozonated gas or water?

Signature: _____ Date _____/_____/_____

Signature of Guardian if applicable: _____ Date: ____/_____/_____

Metabolic Assessment Form™

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

PART I

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

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

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
Abdominal intolerance to sugars and starches	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 fruits and vegetables; 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				
Roughage and fiber cause constipation	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

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
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
Difficulty losing weight	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 VIII				
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 IX				
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	0	1	2	3
Blurred vision	0	1	2	3
Category X				
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

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

Category XI

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 XII

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 XIII

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 XIV

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 XV

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 XV *(Cont.)*

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

Category XVI *(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 XVII *(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 XVIII *(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 XIX *(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:

Jeri Evans Nutrition, Inc.
Daily Food & Mood Log

Date _____

Day _____

To fully assess Nutritional issues **FILL OUT THIS FORM**.
I need to see what you typically eat three days in a row. If you have recently improved your diet, write down one day of what you previously ate and 2 days of what you currently eat.

Time	Amount of Food, Liquids, or Supplements Consumed	Time	Describe Physical, Mental, Emotional Symptoms and Mood*	Time	Describe Bowel Movement*

SOME COMMON SYMPTOMS:** ***Rev. 11/9/13	***Physical and Mental***: bloating, water retention, stomachaches, gas constipation, diarrhea, low energy, fatigue, joint pain, headaches, runny nose, postnasal drip, sleepy after eating, acidic stomach, food cravings, "brain fog", memory, concentration ***Emotional:*** happy, excited, calm, sad, anxious, weepy, angry, depressed, etc. ***Bowel:*** soft, loose or firm; large, medium or small (amount); light or dark color, smelly, bad odor

JERI EVANS NUTRITION, INC.

HEALTH CARE PRIVACY

Notice of Privacy Practices

Protecting Your Confidential Health Information is Important to us. This notice describes how health information about you may be disclosed and how you can get access to this information. Please review it carefully.

The Federal HIPPA (Health Insurance Portability and Accountability Act) laws were written to protect the confidentiality of your health information. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal government to legally enforce the importance for the privacy of health information is the rapid evolution of computer technology and its use is healthcare. The government has appropriately sought to standardize and protect the privacy of electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it.

Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable Client. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse, physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment. We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information. Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by Clients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business, and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing, or credentialing activities. Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our Clients to be sure they receive the best preventative and curative care modern medicine can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders). We will notify government authorities if we believe a Client is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when

we believe we are specifically required or authorized by law or with the Client's agreement. We may be required to disclose to Federal officials or military authorities health information necessary to complete and investigation related to public health or to national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device. As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime. We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participation in providing your care. We may be required by law to provide information to coroners, funeral directors and medical examiners for the purposes of determining a cause of death and preparing for a funeral. Advancing medical knowledge often involves learning from the careful study of the medical histories of prior Clients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval and of an Institutional Review Board.

Client Acknowledgment of Notice of Privacy Practices and Authorization to use or disclose health information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Client Name _____

Client Signature _____ **Date** _____

YOUR RIGHTS

Restrictions - You have the right to request on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our Clients.

Confidential Communications - You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor reasonable requests for confidential communication.

Inspect and Copy Your Health Information - **You have the right** to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information - **You have the right** to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for change. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information - You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your requests to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice - You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all of our Clients receive a copy of this notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy has been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Jeri Evans Nutrition, Inc.

The Business and Professions Code of the State of California

The following is Pursuant to State of California Senate Bill 577 Section 2053.6

*** All clients must read, understand and sign this disclosure ***

I The Nutrition Services and Intuitive Release Therapy provided by Jeri Evans Nutrition, Inc. do comply with Section 2053.6 and 2053.5 of the Business and Professions Code of the State of California. In compliance with this code, one must be advised:

A There are NO licensed physicians in the office connected with Jeri Evans Nutrition, Inc. and the individuals performing Nutrition Consultation and/or Intuitive Release Therapy are not physicians.

This means and implies that he/she cannot and will not:

- Conduct surgery or any other procedure on another person that punctures the skin or harmfully invades the body.
- Administer or prescribe X-Ray or radiation to another person.
- Prescribe or administer legal drugs or controlled substances to another person.
- Recommend the discontinuance of legal drugs or controlled substance prescribed by an appropriately licensed practitioner.
- Willfully diagnose & treat physical or mental condition of any person under circumstance or condition that cause or create a risk of great bodily harm, serious physical /mental illness, or death.
- Set fractures or Treat lacerations or abrasions through electrotherapy.
- Hold out, state, indicate, advertise to a client or prospective client that he/she is a physician/surgeon.

B Nutrition Consultation and Intuitive Release Therapy are alternative or complimentary to the healing arts services.

C The therapist that provides the service of Nutrition Consultation and Intuitive Release Therapy is not licensed by State of California

D All services provided by Jeri Evans Nutrition, Inc. have never been in any clinical or medical trials or studies to prove the therapies either beneficial or harmful.

II Jeri Evans's Education:

- Bachelor of Science Degree in Foods and Nutrition
- Practitioner of Past Life Therapy
- Certificate from the Institute of PSI Biotics

III Services:

A Nutrition & Weight Management may include the following:

- Review of past and current food plans
- Discussion of nutritional deficiencies
- Reviewing client signs, symptoms, metabolism from the health histories, forms and current status

- Discussion of laboratory tests
- Discussion of diet plans
- Discuss and review supplement list
- Weight, height and body measurements

B Intuitive Release Therapy:

The client and Jeri Evans discuss personal goals. They and relax into a meditative state by breathing and utilizing visualization techniques. Jeri Evans is an Empath, Medium and Clairvoyant. All three modalities maybe incorporated into the session.

C Spiritual Counseling:

Jeri Evans is an Empath, Medium and Clairvoyant. All three modalities may be incorporated into the session to contact answer questions or contact those that have passed on.

I acknowledge that I have read the above disclosure and have been given a copy of this document. The information was provided to me in a language I can read and understand. Any questions should be asked at the time of the first visit. For further explanation of services, I will read the pamphlets provided or access Jeri Evans Nutrition, Inc. website, www.jerievansnutrition.com.

Client Signature _____ Date _____/_____/_____

I understand that as a condition of any agreement to provide services to me, I agree to waive any and all claims, causes of action and lawsuits that I may have, believe that I have, now or at any future date against Jeri Evans or Jeri Evans Nutrition, Inc. for services already provided or to be provided in the future, for any amount in excess of the fee that I have paid for such services.

Client Name (Print) _____

Client Signature _____ Date _____/_____/_____