

CONTACT INFORMATION

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE: HOME () WORK () CELL ()

E-MAIL: _____

Can New Metabolism e-mail you at this address? YES NO

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

EMERGENCY CONTACT: _____ PHONE ()

REFERRED BY: _____

NUTRITION QUESTIONNAIRE:

Reason for consultation and/or goals: _____

How many meals do you eat per day? _____

Describe typical meals, snacks and drinks and time of each (please be specific and very complete—mention exact kinds of meat, vegetables and brand names if possible.):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you smoke? Drink alcohol? How much/when?

Do you drink caffeine every day? If so, what type?

Do you ever overeat? If so, which foods and how often?

Do you have any food allergies, restrictions or sensitivities?

Describe your daily energy levels:

Do you get noticeably irritable, lightheaded or weak if you haven't eaten in a while?

Do you crave any of the following?

- | | | | |
|----------------------------------|--------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bread | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Desserts |
| <input type="checkbox"/> Fat | <input type="checkbox"/> Fish | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Meat |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Sugar | <input type="checkbox"/> Other: _____ | |

Do you take any nutritional supplements or vitamins? YES NO

If so, which ones? (Please be specific and attach additional sheet if necessary):

Which prescription and over-the-counter medications do you take regularly?

Which oils do you use/consume?

- | | | | |
|--|--|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Canola | <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Corn Oil |
| <input type="checkbox"/> Crisco | <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Margarine | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Soybean Oil | |
| <input type="checkbox"/> Sun/Safflower | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other: _____ | |

How many bowel movements do you have daily?

Do you feel bloated or constipated more than 1-2 days a week?

Rank your skin without lotion:

- Very dry Dry Normal Oily Combination

Women: Please check any that pertain:

- Birth control pills
- Children
- Irregular periods
- Loss of libido
- Loss of periods
- Menopause
- Painful intercourse
- Painful periods
- PMS

Men: Please check any that pertain:

- Difficulty urinating
- Difficulty w/erection
- Frequent urination
- Loss of libido
- Prostate enlargement

Please check any of the following that pertain to you (past or present): BASAL METABOLIC RATE QUESTIONNAIRE:

- Acne
- Addition (*alcohol, drugs*)
- Anemia
- Anorexia
- Anxiety or nervousness
- Arthritis (*Rheumatoid or Osteo*)
- Bladder infections (*Cystitis*)
- Bloating, gas or indigestion
- Blood sugar problems
- Bronchitis
- Cancer
- Colds or flu (*frequent*)
- Cold sores
- Chronic fatigue
- Constipation
- Dandruff
- Depression
- Diabetes I
- Diabetes II
- Diarrhea
- Difficulty losing weight
- Difficulty gaining weight
- Emotional problems
(instability or sensitivity)
- Emphysema
- Fainting
- Gall bladder problems
- Gout
- Hair loss or poor
hair growth
- Headaches
- Heart disease or problems
- Heartburn
- Hemorrhoids
- Herpes simplex Type I or Type II
- High blood pressure
- High cholesterol
- HIV
- Hot flashes
- Hypoglycemia
- Insomnia
- Intestinal problems
- Kidney stones
- Liver problems
- Loose stools
- Memory loss or confusion
- Nails, poor growth
- Nails, white spots
- Panic attacks
- Parasites
- Pregnant or nursing mother
- Respiratory problems
- Ringing in ears
- Seizures
- Severe mood swings
- Skin conditions
- Stroke
- Suicidal tendencies
- Thyroid condition
- Ulcer
- Yeast Infection

BASAL METABOLIC RATE QUESTIONNAIRE:

PLEASE MARK YES OR NO TO THE FOLLOWING:

- | | | | |
|----|--|---|---|
| 1. | Do you experience undo cold in your extremities? | Y | N |
| 2. | Is your energy level low, especially by mid-afternoon? | Y | N |
| 3. | Have you failed to lose weight on low calorie diets? | Y | N |
| 4. | Have you experienced any sudden, unexplainable weight gain at any time in your life? | Y | N |
| 5. | Do you now or have you ever consumed alcohol in quantity (3 or more drinks per day)? | Y | N |
| 6. | Do you have any family history of hypothyroid? | Y | N |

A BMR TEST IS RECOMMENDED TO ANYONE WHO ANSWERS YES TO TWO OR MORE OF THE ABOVE QUESTIONS.

LIABILITY WAIVER

Welcome to my practice. As you know, I am a practitioner of nutrition. I am not a licensed physician, nor are nutrition services licensed by the state. The idea behind nutrition is that:

When properly grown and prepared, foods and the nutrients found in foods, can be supportive of health, enhancing quality of life and well-being.

As a practitioner of nutrition, I will provide you with the followings kinds of services:

- Diet and nutrition evaluation
- Individualized dietary guidance appropriate to your lifestyle and environment
- Education and research on your health concerns
- Health support complementary to that provided by licensed professionals

I have been practicing nutrition for 8 years. My training and education includes:

- Bachelor of Science - Dietetics
- Bachelor of Science - Biology
- Memberships:
 - International Association of Eating Disorder Professionals
 - American Association of Nutritional Consultants
 - American College of Nutrition
 - American Nutraceuticals Association
 - American Dietetics Association
- Academic training
- Nutrition Educator Certification
- Nutrition Consultant Certification

In order to use my services, California state law requires that you acknowledge receipt of the information provided in this form and that you sign it. You will receive a copy. I will keep the original in my records for at least three years. All information is confidential.

My services in nutrition are alternative or complementary to healing arts that are licensed by the State of California. Under Sections 2053.5 and 2053.6 of California's Business and Professions Code, I can offer you these services, subject to requirements and restrictions that are described fully on the patient information sheet (see www.californiahealthfreedom.org).

If you ever have any concerns about the nature of my services or our work together, please contact me right away. I recommend that you inform your medical doctor that you are receiving nutrition services.

Acknowledgement and Consent to Receive Services:

I have read and understand the above disclosure about the nutrition services offered by Derek Johnson and his training and education. I have discussed with Derek, the nature of the services to be provided. I understand that Derek is not a licensed physician and that nutrition services are not licensed by the state. I understand it is my responsibility to maintain a relationship for myself/my child with a medical doctor or licensed health provider. I have consented to use the services offered by Derek, and agree to be personally responsible for the fees of Derek in connection with the services provided to me. I understand 48-hour notice to re-schedule must be given or a full-session fee will be charged. I am here as an individual on my own behalf.

Signed: _____ Date: _____
(client/parent/conservator/guardian)



CREDIT CARD AUTHORIZATION FORM

I hereby authorize my signature to be on file with New Metabolism 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 New Metabolism to run my credit card the day my appointment has taken place and or when 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.

For New Clients Only: No additional fee is charged for the cancellation and rescheduling of the Initial Appointment of new clients if made 48 hours or more before the originally scheduled time. If a cancellation is made on the Initial appointment 48 hours or less, a \$95 non-refundable fee will be charged. All other appointments follow the same policies as listed above.

REMINDER: New Metabolism offers phone and Skype web conferencing appointments for your convenience.

Client Name: _____

Card Type: VISA MASTERCARD (AmEx is not accepted)

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 sign and fax completed form to **310-388-5702**



BODY COMPOSITION ANALYSIS

The Tanita Body Fat Composition Analysis measures the impedance of a current as it travels through the water stored in your body's muscle and fat. The more muscle you have, the more water your body holds which allows the current to pass through your body much faster. With more fat, the slower the current passes through your body creating more impedance.

This test is simple and provides important data showing your fat mass, lean tissue mass (muscle), body fat % and more allowing you to track the changes in your body's composition. The Tanita accurately captures whether you are losing or gaining weight through the loss or gain of fat and muscle in different areas of your body.

Test Preparation Instructions:

Day before test (24 hours prior):

- do not drink alcohol

Day of test: On the bottom of your feet, do not use lotions or antibacterial washes

3/4 hours prior:

- do not exercise
- do not eat a large meal (small snacks are okay)

2 hours prior:

- drink 2-3 glasses (8 oz.) of water (hydration is key for accuracy)

Caution:

This test is **not recommended** for:

- Pregnant women
- Persons with implanted electronic devices
- Persons with diagnosed heart problems

Consent:

I have read these test preparation instructions and cautions and hereby consent to have a body composition analysis by my dietitian at New Metabolism.

Signature _____ Date _____

Printed Name _____

NEW METABOLISM
NUTRITION JOURNAL

DATE:

WATER GOAL
OZ

1

_____ TIME ____:____

2

_____ TIME ____:____

3

_____ TIME ____:____

4

_____ TIME ____:____

5

_____ TIME ____:____

6

_____ TIME ____:____

16
32
48
64
80
96

Energy: *poor* *average* *good* *excellent*

Digestion: _____ BM: 1 2 3

Sleep: _____ Hours: _____

Appetite: _____

Exercise: _____

Mood: _____