Joanna K Chodorowska, BA, NC
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Nutritional Analysis

Date: _____ Blood Type: _____

Name: _____Ancestry:_____
Address: _____
_____
Phone: (home) _____ (work) _____(cell) _____
Email address: _____
Last physical exam: _____performed by whom?: _____ contact info:
Health concerns/ issues: _____
Birthday: _____Single __Married ___ Kids/ages? _____
Age: _____ weight: _____ height: _____ M/F: _____
Desired weight: _____ wt to gain: ____ wt to lose: ____ Date to achieve desired weight? _____
Reasons for wanting to lose/ gain weight: _____
_____
Reasons for seeing a nutritionist: _____
How did you hear about me? __ friend (_____) __ magazine ad (_____)
__website __ other (_____)

Do you smoke or use tobacco products? _____ Does anyone smoke in your home? _____
If yes, how many packs per day? You _____ someone else _____
Do you use over the counter drugs? Yes _____ No _____
If yes, what do you take? _____ for what symptom? _____
how much, how often? _____
Do you take prescription drugs? Yes _____ No _____
If yes, what do you take? _____ for what symptom? _____
How much, how often? _____
How much water do you drink per day? _____ glasses
Is it filtered or purified? Please specify: _____
How many cups of coffee _____, soda _____, or black tea _____ do you drink daily?
How many cups of diet soda _____, diet tea _____ or diet drinks _____ do you drink daily?
Which artificial sweeteners are you most familiar with? (check those you know; mark with an "X" if you use that one)

__ Aspartame __ Saccharin __ Sucralose __ Equal
__ Acesulfame-K __ NutraSweet __ Splenda __ other _____

Do you take nutritional supplements (vitamins)? Yes ___ No ____
If yes, please list what you take. Please include brand, type, quantity taken per day:
_____
_____
_____

How would you rate your knowledge of nutrition and nutritional supplements?
__ excellent __ fairly good __ poor __ know nothing

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Do you exercise? Yes ___ No ___
If yes, how often? _____ what kind of exercise? _____
How long? _____ what intensity? _____
What time of day? _____ before meal? Y__N __ after meal? Y__ N___

What is your occupation? _____
How many hours on average do you work per week? _____
How would you describe your job?
__ physical __ mental __ stressful __ rewarding
__ easy-going __ secure __ non-secure __ exhausting
__ relaxing __ demanding __ other _____
What do you do when you come back from work? Please include hobbies, etc:
_____
_____

Do you drink alcohol? Yes ____ No ____
If yes, how much and how often? _____
_____ beer _____ wine _____ spirits _____ mixed drinks
Do you have food allergies? Yes ___ No ___ Not sure ____
If yes, to what? _____
_____
Do you have food cravings? Yes ____ No _____
If yes, what do you crave? (chocolate, salty snacks, sweets, cookies, etc)
_____
_____
Do you avoid certain foods? Yes ____ No ____
If yes, what do you avoid and why? _____
_____

Do you experience the following on a regular basis (mark as D-daily, W-weekly, M-monthly, etc) ?

__ acid reflux	__ nausea	__ IBS	__ diarrhea	__fatigue
__ constipation	__ headaches	__ migraines	__ back pain	__pain
__ indigestion	__ fatigue/ tired	__ cannot sleep	__ cannot stay asleep	__heartburn
__ sinus congestion	__ runny nose	__ post nasal drip	__ depression	__anxiety
__ other (please list: _____)		__ stress	__ other _____	__mood swings

For females only: Do you have PMS? Yes ___ No ___
If yes, what symptoms?: please check all that apply
__ bloating/ water retention __ chocolate cravings __ anxiety
__ moodiness __ tender breasts __ other
__ hot flashes __ menopause – describe _____
Is your period regular? Yes ___ No ____ Not applicable ___
If no, what makes it irregular? (eg. irregular duration, irregular cycle, some heavy flow, some light, etc) _____

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Please circle the foods you like.
Mark the ones you 'hate' with a line thru that item.

Fruits	**Vegetables**	**Proteins**	**Beans/ legumes**	**Other**
Apple	Carrot	Lamb	Black beans	Basil
Banana	Eggplant	Beef	Lima beans	Onion
Cantaloupe	Iceburg lettuce	Venison	Kidney beans	Leek
Pear	Romaine lettuce	Salmon	Cannelini beans	Garlic
Pineapple	Peas	Swordfish	Soybeans/ edamame	Parsley
Cranberry	Green beans	Lobster	Peanut	Cilantro
Blueberry	Potato	Scallops	Almond	Chives
Honeydew melon	Tomato	Shrimp	Soybeans, dry, roasted	Oregano
Grapes, red	Beet	Turkey	Cashews	
Grapes, green	Sweet potato	Chicken	Tofu	**Dairy**
Orange	Radish	Liver, calf	Pinto beans	Milk
Lemon	Radicchio	Liver, chicken	Baked beans	Yogurt
Lime	Endive	White eggs	Walnuts	Sour cream
Kiwi	Broccoli	Brown eggs	**Grains**	Butter
Mango	Sugar snap peas	Egg whites	Wheat	Cheese
Papaya	Cauliflower	Lamb	Oats	Soy milk
Strawberry	Turnip	Tuna	Quinoa	Rice milk
Raspberry	Parsley	Other fish	Corn grits	Almond milk
Apricot	Cilantro		Bread, white	Goat's cheese
Plum	Zucchini		Bread, multi-grain	Sheep cheese
Prune	Yellow squash		Corn chips	Goat yogurt
Peach	Pumpkin squash		Pumpernickel	
Pluot	Cabbage, red		Rice, white	
Plantain	Cabbage, white		Rice , brown or wild	
			Amaranth	
			Spelt	

Please list any other foods which you do not like at all (and the reasons why):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

_____ _____

List current health problems for which you are being treated: _____

_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

Do you experience any of these general symptoms E V E RY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): _____

_____

_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

_____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

_____

What are your current health goals: _____

_____

_____

_____

_____

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ −

PAP ❑ + ❑ −

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

7/00, Rev 1/03, Rev 3/06

FirstLineTherapy® Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: □ *Past 30 days* □ *Past 48 hours*

Point Scale	0	*Never* or *almost never* have the symptom
	1	*Occasionally* have it, effect is *not severe*
	2	*Ocasionally* have it, effect is *severe*
	3	*Frequently* have it, effect is *not severe*
	4	*Frequently* have it, effect is *severe*

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

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For the following section, please write down as accurately as possible, everything that you have eaten and drank for the past 2-4 days. Please be as specific as possible. Also include coffee (specify if caf/decaf), alcoholic beverages, soda (what kind or if diet), candy bars, etc and estimate the serving sizes (1 cup, 8 oz liquid, etc). If you drink milk, please indicate if whole, 2% or skim, etc. Please explain as well as possible how the food was prepared, eg. 1 chicken breast – fried, baked or broiled? With skin? Breaded? Marinated? In what? What type of oil was used, etc.

Day 1 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)

_____
_____
_____

Snacks: (what time? _____)

_____
_____

Lunch: (what time? _____)

_____
_____
_____
_____

Snacks: (what time? _____)

_____
_____
_____

Dinner: (what time? _____)

_____
_____
_____
_____
_____

Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Day 2 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____
Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____
Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Day 3 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____
Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____
Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

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Day 4– day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____
Breakfast: (what time? _____)
_____
_____
_____

Snacks: (what time? _____)
_____
_____

Lunch: (what time? _____)
_____
_____
_____
_____

Snacks: (what time? _____)
_____
_____
_____

Dinner: (what time? _____)
_____
_____
_____
_____
_____
Is this your usual way of eating? Yes ____ No ____
If no, what made it different? _____
_____

Additional comments: _____
_____

Thank you for your participation. *Joanna K Chodorowska, BA, NC*

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~ healthy nutrition for everyday living ~
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Nutritional Client Statement

I hereby understand to the following:

I fully understand that *Joanna K Chodorowska* is not a medical doctor or practitioner and that *Nutrition in Motion*, at *106 Pimlico Way* is not a medical practice or medical place of practice. I am not here for medical diagnostic or treatment procedures.

The services performed by *Joanna K Chodorowska/Nutrition in Motion* are restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health and do not involve diagnosing, prognosticating, treatment of prescribing of remedies for the treatment of disease or any act which will constitute the practice of medicine in this state in which a license is required for such practices. Please consult your physician before starting a new program.

Date: _____

Signed: _____

Print Name: _____

Name of client if not over 18: _____

Birthday: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Work: _____

Email: _____

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CANCELLATION POLICY

Effective May 6, 2013

Appointments that are cancelled and rescheduled by phone 24 hours prior to the appointment will incur no additional charges. Cancellations made the same day will incur a full charge as I am not able to replace the appointment. Cancellations the night before for an early morning appointment or same day cancellations will incur a half price charge for the scheduled length of the appointment, even if the appointment is rescheduled. If you reschedule right away, I will be less likely to charge for missing an appointment time. I am not an ogre!!

You are paying for the time slot. If you are late for your appointment, you will be charged for that session from the time it was supposed to start. Please call 215-272-6774 at any time with any changes to the schedule. Sending an email is not adequate as I may not receive the email until after the appointment time. Please realize that I am not in front of my computer all day. You must call to cancel or reschedule the appointment in order to avoid being charged for the session.

Missing your appointment (aka. no show) will incur full charge for the appointment plus an additional 10% fee for my driving time, if applicable. Forgetting to 'write the appointment in your calendar' is not a valid excuse for missing an appointment. I will try my best to confirm appointments, but since most are scheduled within 1 weeks time, a reminder seems unnecessary. Emergency situations will not be included in this policy.

Sessions that are pre-purchased as in packages, will be forfeited after 1 year if not used. It is not my responsibility to remind you that you have sessions left. I will keep track of sessions used most of the time, but unused sessions will be lost after a year of purchase.

Thank you for your understanding and cooperation. I look forward to working with all of you to help you reach your goals nutritionally. To YOUR health!

Founder, President
Nutrition in Motion, LLC

I have read and agree to this policy. I agree to pay any charges resulting if I do cancel within the parameters of this agreement. If you do not feel comfortable with providing PayPal info, please check here __ and sign the document agreeing that you will pay for the missed appointment by either cash or check.

_____ _____

Name **Date** PayPal account (email address used for PP)

_____ _____

Signature email to use for communication if diff than PP

_____ _____

MC/VS exp date/ 3-digit code on back

_____

_____

Billing Address