



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) _____

HEALTH HISTORY

Name _____ Date _____

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

Marital Status: Single Partner Married Separated Divorced Wdow(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 EVERY 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
- Bum 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

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	3 Frequently have it, effect is not severe
	1 Occasionally have it, effect is not severe	4 Frequently have it, effect is severe
	2 Occasionally 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
 _____ Bloating 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: _____



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