C: Angela T Russo
P: 914-888-6785
E: info@nutritionkey.com

A. IDENTIFICATION

NAME:____ DATE: __________________

AGE: ______ BIRTHDATE: ______/______/______ SEX: M / F

ADDRESS: _____________________________________CITY: __________________________

STATE: __________________ ZIP: ________________

PHONE (H):____________________ (W) __________________ (C) _____________________

BEST EMAIL: ____ TEXT: Y / N

OCCUPATION: _____________________________ RETIRED: Y / N

FAMILY STATUS: SINGLE / DIVORCED / MARRIED / WIDOW (ER) / SIGNIFICANT OTHER

EMERGENCY CONTACT: ______________________PHONE #: _______________________

PARENT OR GUARDIAN (IF UNDER 18): ____

HOW DID YOU HEAR ABOUT US?_______________ REFERRED BY: __________________

PHYSICIAN NAME: ____

PHYSICIAN ADDRESS: _______________________________PHONE #: _____________

REASON FOR VISIT:

____

____

____

CANCELLATION POLICY

As a courtesy to our staff and other patients, we ask that our office receive notice of an appointment cancellation within 48-hours. Failure to cancel within and/or no shows will be charged at the full cost of your scheduled consultation.

SIGNATURE:____________________________________ DATE: ______________________

PATIENT NAME: ______________________________________

ADD ME TO YOUR EMAIL LIST SO I CAN RECEIVE YOUR MONTHLY NEWSLETTER Y/ N

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B. INSURANCE INFORMATION

This office does not accept insurance for services; however, some lab tests may be submitted under your insurance provider through your medical doctor.

Angela T. Russo does not diagnose or treat any disease; for this you must see a licensed health professional. However, she will teach you how to bring your body, mind and spirit into balance, so your body's innate health building capacity can be maximized.

I understand that Nutrition Key is not a medical facility and does not diagnose, treat or prescribe. Instead, Angela teaches me to build my health naturally, and I will not hold her or Nutrition Key, Inc. responsible for my health or any health-related conditions.

Signature ________________________________ Date ________________

Medical History: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible health care to you (or your child), it is necessary to have the following information.

C. CHIEF COMPLAINT

PLEASE LIST YOUR MAJOR PROBLEMS AND/OR SYMPTOMS AND THE APPROXIMATE DATE IT BEGAN. (If none please write the reason for seeking this consultation.) Please rank in order of importance to you.

Symptom/problem: **When problem began:**

1. ____/________________

2. ____/________________

3. ____/________________

4. ____/________________

5. ____/________________

6. ____/________________

7. ____/________________

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What do you expect to achieve as a result of your treatments at Nutrition Key?

____
____
____
____
____
____

If you have seen other practitioners for these problems, what were the results?

____
____
____

D. HAVE YOU EVER HAD OR HAVE?	**YES**	**NO**
1. Asthma, hay fever, sinusitis or other allergies		
2. Allergy to penicillin, aspirin, local or general anesthetic or other drugs Specify:		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or jaundice		
9. Epilepsy or nervous disorders		
10. Bleeding or clotting disorders		
11. Arthritis, autoimmune diseases, bone disorders, joint replacement		
12. Venereal Disease, herpes, sexual transmitted disease		
13. Acquired Immune Deficiency Syndrome (AIDS)		
14. Any other illness		

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15. Any wounds heal slowly or present complications		
16. Presently taking any medicine; specify		
17. Are you presently under the care of a physician?		
18. When was your last physical exam?		
19. Have you ever been hospitalized?		
20. Have you had X-ray treatments or chemotherapy?		
21. Are you presently on a diet?		
22. Women – Are you pregnant?		
23. What is your tobacco history?		

E. YOUR PAST MEDICAL HISTORY

Please indicate if you have had any of the following problems, noting years affected.

Alcoholism ______________________________
Allergies ______________________________
Anemia ______________________________
Arthritis ______________________________

Asthma ______________________________

Bleeding / Bruising ____________________
Cancer ______________________________

Crohn's Disease / Colitis________________

Depression ____________________________
Diabetes ______________________________
Digestive Disease______________________

Drug Problems_________________________
Eating Disorder _______________________
Heart Disease _________________________
Herpes_______________________________
HIV _________________________________
Hypoglycemia _________________________
Hepatitis ____________________________
High Cholesterol_______________________
High Blood Pressure ___________________
Irritable Bowel ________________________

Do you have a primary care provider?
Yes [ ] **No [ ]**

If Yes, complete provider's information:
Name: ________________________________
Address: ______________________________
____

Phone: ________________________________

Your Tests (specify when & any info):

Last Physical Exam: ____________________

Chest X-Ray: __________________________
EKG: _________________________________
Blood Tests:

____

Urine Tests: ___________________________
Rectal Exam: __________________________
PAP Smear: ___________________________
Breast Exam: __________________________

<u>Immunizations</u>: Specify when & if known
Smallpox: _____________________________
Polio: ________________________________
Measles/Mumps/Rubella:________________
Pertussis: _____________________________

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Kidney Disease ______________________
Lupus ______________________
Lyme Disease ______________________
Mental Illness ______________________
Migraine Headache ______________________
Multiple Sclerosis ______________________
Pneumonia ______________________
Polio ______________________
Rheumatic Fever ______________________
Stroke / TIA ______________________
Seizures ______________________
Stomach / Intestinal Ulcers ______________________
Tuberculosis ______________________
Thyroid Disease ______________________
Venereal Disease ______________________

Diphtheria:______________________
Tetanus: ______________________
Influenza: ______________________
Hepatitis B: ______________________
Chicken Pox: ______________________
Other:______________________

Hospitalization & Surgeries (dates/ type):

____
____
____
____
____
____
____

F. FAMILY HISTORY

For each family member, write age or age at death and any medical problems.

Mother: ______________________
Grandmother: ______________________
Grandfather: ______________________
Father: ______________________
Grandmother: ______________________
Grandfather: ______________________
Siblings:______________________
____
____
____
____
Children: ______________________
____
____
____

G. LIFESTYLE AND HABITS

Tobacco:
Do you currently smoke? ____________
Do you currently chew? ____________

If yes:
How much per day? ____________
For how long? ____________
If no:
Did you ever smoke? ____________
For how long? ____________
When did you stop? ____________

Alcohol
(Include wine, beer and liquor)
How often do you drink?
[ ] Never
[ ] Less than 1 time per week
[ ] 2 -3 times per week
[ ] At least once daily

What do you drink?
____
____

Was drinking ever a problem?
Yes [ ] **No [ ]**

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H. CURRENT MEDICATIONS

Please write name, dosage and how often taken.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

Please list any medications you may have an allergy to and the type of reaction.

____

____

____

____

Caffeine

How many cups of the following do you consume daily?

Coffee________

Black Tea _____

Green Tea _____

Cola __________

Diet Cola ______

Chocolate _____

Recreational Drug Use:
(type/frequency) ______________________

Over the Counter Medications:

(type/frequency) ______________________

____

Please list any dietary supplements/ herbs you currently take:

____

____

____

____

Nutrition Key™
Unlock Your Healing Potential

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SYMPTOMS AND SYSTEMS REVIEW: Write all appropriate letters on line to the left.
DO NOT fill in anything if the problem does not apply to you.

Write "C" for a current problem
"I" if it is an intermittent problem
"P" for a past problem

_____ headaches
_____ neck lumps or swelling
_____ loss of balance
_____ dizzy spells
_____ vertigo
_____ blackouts or fainting
_____ blurry vision
_____ double vision
_____ cataracts
_____ eye pain or itching
_____ watering eyes/redness
_____ hearing difficulties
_____ earaches
_____noises or ringing in ears
_____ recurrent ear infections
_____ dental decay/problems
_____sore/bleeding gums
_____ sore tongue
_____coated tongue
_____ loss of taste or smell
_____ sores in or around mouth
_____difficulty swallowing
_____ cold sores or fever blisters
_____ sinus or nasal congestion
_____ runny nose
_____ frequent colds
_____ nasal polyps
_____ sore throats

_____ high blood pressure
_____ skipped heartbeats
_____ racing heart
_____ chest pain or pressure
_____ swollen feet or ankles
_____ difficulty night breathing
_____ varicose veins or phlebitis
_____ recurring indigestions
_____ nausea or vomiting
_____ intestinal gas / flatulence
_____ belching
_____ bloating
_____ abdominal pain/cramps
_____ constipation
_____ diarrhea or loose stools
_____ rectal itching
_____ blood with stools
_____ black stools
_____ pain in rectum
_____ jaundice
_____ hepatitis / pancreatitis
_____ colitis
_____ Crohn's Disease
_____ diverticulitis /diverticulosis
_____ brown or red urine
_____ frequent urination
_____ decreased force of urine
_____ continual urge to urinate

_____ weakness
_____ painful feet
_____ leg cramps
_____ trembling or tremors
_____ seizures or epilepsy
_____ numbness or tingling
_____ skin tumors
_____ dry skin
_____ acne
_____ eczema
_____ skin rashes
_____ psoriasis
_____dandruff or seborrhea
_____ hives
_____ itching or burning skin
_____ easy bruising
_____ hypothyroid (low)
_____ hyperthyroid (high)
_____ weight gain
_____ weight loss
_____ feel excessively warm
_____ feel excessively cold
_____ loss of appetite
_____ constant hunger
_____ fatigue or weariness
_____ night sweats
_____ diabetes
_____ low blood sugar

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_____ swollen glands
_____recurrent fevers or chills
_____ hoarse voice
_____ shortness of breath
_____ wheezing or gasping
_____ coughing
_____ coughing blood
_____ chest colds/pneumonia
_____ heart murmur

_____ involuntary urination
_____difficulty starting urination
_____ kidney/bladder infection
_____ venereal disease
_____ osteoporosis
_____ back or neck pain
_____ aching muscles/joints
_____ arthritis
_____ joint stiffness

_____ nervousness/anxiety
_____ depression
_____ suicidal thoughts

MEN ONLY

_____ sexual dysfunction
_____ hernia
_____ prostate problems
_____ painful testicles

DIET SURVEY

Please check all the following statements, being careful to use the appropriate box related to the frequency of your personal habits.

"FREQUENT" = at least once per day; "OFTEN" = several times per week; "OCCASIONAL" = once a week or less; "SELDOM" = once or twice per month or less; "NEVER" = almost total avoidance

Frequent	Often	Occasional	Seldom	Never	1. alcoholic beverages
					2. eat at restaurants
					3. eat at fast food restaurants
					4. pastries, cookies, candies, ice cream, other sweets
					5. add sugar to coffee, tea, cereals or other foods
					6. colas or other soft drinks
					7. instant breakfasts, pop tarts, doughnuts, muffins
					8. cold breakfast cereals
					9. caffeine (coffee, tea, cola, chocolate)
					10. deep-fried foods
					11. margarine of any type
					12. whole grain hot cereals (oatmeal, wheatena, etc.)

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					13. meat (beef or veal, pork or ham, lamb, liver)
					14. chicken or turkey – circle: regular or free range
					15. fresh fish
					16. processed meat (bologna, turkey roll, sausage, etc.)
					17. fresh raw fruit
					18. fresh vegetables
					19. salads
					20. whole-grain breads
					21. white bread/flour products
					22.beans and legumes
					23. yogurt— circle: whole or low fat; plain or flavored
					24. milk – circle: whole, lowfat or skim
					25. cheese
					26. eggs – circle: regular or free range
					27. salt
					28. herbs, fresh and dried, or spices
					29. drink adequate water – circle: tap, filtered, bottled
					30. eat excessively if bored or depressed
					31. swallow food before chewing well or hurried/rushed meals
					33. stuff yourself
					34. read food labels
					35. sneak or hide food
					36. adequate fiber or roughage
					37. artificial sweeteners
					38. shop at health food stores