

REGISTRATION FORM

PATIENT'S INFORMATION			
Title			
Surname	Name	DOB:	Age
		___ / ___ / ____	Gender
			<input type="checkbox"/> M
			<input type="checkbox"/> F
Address			
Telephone number			
Email address			
Where did you hear about me?			
<input type="checkbox"/> Recommendation	<input type="checkbox"/> Website	<input type="checkbox"/> Magazine	
<input type="checkbox"/> Radio	<input type="checkbox"/> Poster, leaflet	<input type="checkbox"/> Neal's Yard Remedies	
<input type="checkbox"/> Social media	<input type="checkbox"/> Other:		
GP DETAILS			
GP's name and/or Practice	Address	Telephone number	
NEXT OF KIN			
Name	Relation to you	Mobile number	Home number

ARE YOU?

YES

NO

DETAILS

Harmony & Balance

Ms Monika Jakiel-Rusin RNutr

MSc in Dietetics

mnkjakielrusin@gmail.com

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Receiving treatment from a Doctor, hospital or clinic?			
Taking any prescribed medicines eg. tablets, injections, ointments or inhalers?			
Taking any supplements?			
Taking contraceptives or hormone replacement therapy?			
Pregnant?			

Are you currently or have you ever suffered from: Yes No Details :

Allergies to medicines (eg. Penicillin) or food?			
Bronchitis, asthma or chest conditions?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, high blood pressure or stroke?			
Diabetes?			
Bone or joint disease?			
GASTROINTESTINAL CONDITIONS: gastritis; hyperacidity (acid dyspepsia), peptic ulcers, helicobacter pylori; intestinal parasites (parasitic worms); inflammation of the liver / pancreas / gallbladder; gastro-oesophageal reflux disease (GORD); constipation ; bloating; diarrhoea; nausea			
THYROID PROBLEMS			
ANAEMIA			
Liver disease (eg. Jaundice, hepatitis) or kidney disease?			

I declare that the above information is true and correct. It was made with the best of my knowledge:

SIGNATURE.....

HEIGHT: check your height before testing

WEIGHT: check your weight before the testing (on the same day)

WOMEN: should ideally be tested in the middle of their menstrual cycle when water retention is at its minimum

HYDRATION: don't consume large amounts of water before the testing

DEHYDRATION: testing body water levels that are unusually low may affect reading

MEDICATION: some medications, particularly diuretics may affect reading

EXERCISE: no testing for at least 12h after exercise

ALCOHOL: no alcohol for at least 24h prior to testing

COFFEE/TEA: no coffee, tea, fizzy or energy drinks for at least 24h prior to testing

MEALS: test at least 2-3 hours after a meal

URINATE: urinate 30min before testing

MEASUREMENTS

- will be taken from the right side of the body, lying down
- the electrodes will be placed on your right hand and right bare foot
- you will be lying down for at least 5-10min before commencement of the test

INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELLING

I _____ give consent to Monika Jakiel-Rusin to provide Nutrition Counselling and/or BioScan analysis, and/or Personal Training Sessions to myself or the client for whom I am legally

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responsible. The sessions will provide information and guidance about health factors within my own control: my diet, nutrition, and lifestyle. I understand that Monika Jakiel-Rusin is a Registered Nutritionist & a Personal Trainer -not a medical physician- and does not dispense medical advice, nor will she diagnose or treat any medical condition, but will provide nutritional & exercise support & education for disease prevention or an already diagnosed condition. She provides education to enhance my knowledge of health through the use of whole foods, dietary supplements, physical activity and emotional awareness. While that support can be an important complement to my medical care, I understand these services are not a substitute for medical care. Methods of nutritional and fitness assessment, such as BioScan testing, made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive programme for me, and to monitor my progress in achieving my goals. Medical records and personal information and history divulged in session to Monika Jakiel-Rusin will be kept confidential, unless I consent to sharing my medical information. I agree to hold Monika Jakiel-Rusin harmless for claims or damages in connection with our work together. This is a contract between myself and Monika Jakiel-Rusin and I understand that it is also a release of potential liability.

Client or Guardian's Signature Date

Print Name (s)

DIETARY INTERVIEW

1. HEIGHT- WEIGHT- BMI- WAIST CIRCUMFERENCE-

2. PAST OR RECENT DIETS

3. LIFESTYLE : SEDENTARY/ PHYSICALLY ACTIVE (training times)

WAKING UP AND BED TIME:

WORK HOURS:

TRAINING/EXERCISE/PHYSICAL ACTIVITY (time, intensity, frequency)

4. FOOD DIARY

BREAKFAST

LUNCH

DINNER

SNACKS

DRINKS (coffee, tea, juices, fizzy drinks, water, alcohol)

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LIKE OR DISLIKE? ALLERGIES OR INTOLERANCES?

DAIRY

NUTS/SEEDS/FLAXSEED

FRUITS (dried and fresh)

VEG

PULSES

SOYA & SOYA PRODUCTS

MEAT and meat products: offal (liver, kidney) pate, sausage; ham

FISH (seafood, herrings...)

WHOLE GRAINS: rice, buckwheat, barley

CEREAL/CORNFLAKES/OATMEAL/MUESLI/BRAN

BREAD

PASTA

POTATOES

SNACKS (sweet ex. cakes, chocolate or sour ex. crisps)

HONEY

JAM/CONSERVE/MARMALADE/JELLY

SPREADS (peanut butter, marmite, butter...)

SAUCES (soya sauce, sweet chilli, ketchup, mayonnaise, mustard...)

OILS

SALT

SEASONINGS

SUGAR

FAST FOODS/READY MEALS

EATING OUT (where & how often)

OTHER:

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Please fill in with few days worth menu (ideally 7 days or few week days and 1 weekend day)

DATE & DAY	PLACE & TIME	PRODUCT	QUNTITY	EMOTIONS/ SYMPTOMS/ FEELINGS
BREAKFAST I				
MID-MORNING SNACK				
LUNCH				
AFTERNOON SNACK				
DINNER				
EXTRA SNACKS				
DRINKS				

Exercise :

Please fill in with today's date- when filling this form in ; in the results column put your weight and waist measures

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