



Coach: AV BM MP AQ LB

Health Profile

Dietary consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile.

General

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

E-mail: _____ Profession: _____ Employer: _____

Date of Birth: _____ Age: _____

Whom may we thank for referring you? _____

Weight: _____ lbs. Weight 1 year ago: _____ lbs. Min. Adult Weight: _____ lbs at age _____

Maximum Weight: _____ lbs. at age _____ Height: _____

Do you exercise? Yes No

If yes, what kind? _____

How Often and at what intensity? _____

Have you been on a diet before? Yes No

If yes, please specify which diet and why you think it didn't work for you (e.g. too rigid, too much cooking involved, etc.): _____

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's medically supervised weight loss method (10 being the most important): _____

Have you had blood work done within the last 12 months? Yes No

Family Life:

What is your marital status? M S D W Do you have children? Yes No

Number of children: _____ Ages: _____

Medical Information

Please list any physicians you see and their specialty:

Diabetes:

Do you have diabetes? Yes No (if No, skip to next section)

If so, are you under the care of a physician? Yes No

If so, which type?

- Type I – Insulin dependent (insulin injections only)
- Type II – Non-insulin dependent (diabetic pills)
- Type II – Insulin dependent (diabetic pills and insulin)

Is your blood sugar level monitored? Yes No

If so, by whom? Myself Physician Other (specify):

Are you taking any medication? Yes No

If so, please list: _____

Do you tend to be hypoglycemic? Yes No

Cardiovascular Health:

Have you had a cardiovascular event? Yes No

If so, please specify:

How long ago? _____

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Do you have a history of arrhythmia? Yes No

Hypertension:

Do you have high blood pressure? Yes No (if no, skip to next section)

If so, do you have your blood pressure checked? Yes No

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list: _____

Kidney Health:

Have you been diagnosed with kidney disease? Yes No (if no, skip to next section)
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Have you ever had Gout?

Yes No

Liver Health:

Do you have liver problems? Yes No (if no, skip to next section)
If so, please specify: _____
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Colon Health

Do you have: None of these (if none, skip to next section) Irritable Bowel Colitis
 Diarrhea Diverticulosis Crohn's disease Constipation
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Stomach/Digestive Health:

Do you have: None of these (if none, skip to next section) Acid Reflux Gastric Ulcer
 Heartburn Celiac Disease?
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Ovarian/Breast Health:

Check off the situations that apply to you currently: None (skip to next section)

- | | | |
|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Menopause | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Uterine fibroma | <input type="checkbox"/> Cancer (uterus, breast) |

If so, are you under the care of a physician?
Are you taking any medication? Yes No
If so, please list:

Please indicate the date of your last menstrual cycle:

Thyroid Function

Do you have thyroid problems? Yes No (if no, skip to next section)

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list: _____

Emotional Evaluation

Do any of the following apply to you? None of these (if none, skip to next section)

Depression Anxiety Panic Attacks

Bulimia (or history of) Anorexia (or history of)

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Do any of the following apply to you? None of these (if none, skip to next section)

Migraines Fibromyalgia Rheumatoid Arthritis Lupus

Osteoarthritis Chronic Fatigue Syndrome Psoriasis

Other autoimmune or inflammatory condition

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Bone and Joint

Do you currently experience any of the following: None of these (if none, skip to next section)

Neck pain Arm pain Mid back or low back pain Hip pain

Thigh or leg pain Elbow, wrist, knee or ankle pain Headaches

General

Do you have cancer? Yes No

Are you in cancer remission? Yes No

If so, please specify and indicate for how long: _____

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list: _____

Are you generally fatigued or have low energy? Yes No

Are you pregnant? Yes No Are you breastfeeding? Yes No

Do you get cold easily? Yes No Do you have cold hands/feet? Yes No

Do you have other health problems? Yes No

If so, please specify: (recent surgeries, etc..) _____

If so, are you under the care of a physician? Yes No

Are you taking any other medications not listed above? Yes No

If so, please list: _____

Are you currently taking Vitamins, Herbs or Supplements? Yes No

Vitamin, Herb or Supplement Name

Reason

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies

Do you have any food allergies? Yes No

If so, please list:

Do you have any medication allergies? Yes No

If so, please list:

Eating Habits (please be as honest as possible so that we may better help you)

Breakfast

Do you have **breakfast** every morning? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Do you have a **snack** before lunch? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Lunch

Do you have **lunch** every day? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Do you have a **snack** before dinner? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Dinner

Do you have **dinner** every day? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Do you eat a **snack** at night? Yes Sometimes Never

Approximate Time: _____

Examples: _____

Other

Do you prefer: Sweet foods Salty foods Fatty foods

Are you a vegetarian? Yes No

How much pop do you consume per day? _____

How many glasses of water do you drink per day? _____ Glasses

How many cups of coffee do you drink per day? _____ Caffeinated Cups _____ Decaffeinated Cups

Do you smoke? Yes No

If yes, how many packs per day? _____ For how many yrs? _____

Do you drink alcohol? Yes No

If yes, what, how much, and how often? _____

CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger

Score each item on a 0-10 numbering scale. Each feeling represents a different part of the brain and different neurotransmitters

Compulsions/Cravings

Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Never occurs Constant

Appetite

Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Never eat more Always eat more

Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Leave food on plate one plate only seconds thirds

Hunger

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Never hungry Constant hunger

You must take vitamins and minerals while you are on the Ideal Protein Weight-Loss Method. If you stop taking them, you may experience undesirable side effects. _____ (Client's initials)

If you are taking medications, are you interested in getting off any or all of your prescription medications? Yes No

If you have health problems not indicated on this health profile, please consult your physician.

Signature: _____ Date: _____

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.

-----For Office Use Only-----

BW: ____ Brought In ____ Requested on ___/___/___ Received: ____ on ___/___/___

Need Dr. Approval: ____ Dr. Approval Received: ____

Dr. Med. Letter/Notification Sent: ____

DM Notes: _____

	<u>Previous BW</u>	<u>New BW</u>
Total	____	____
LDL	____	____
HDL	____	____
Trigly.	____	____
Glucose	____	____
GFR	____	____