Weight Loss 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 Code: _________________

Phone: __________________ Cell: _________________ Date of Birth: ___________________

How did you hear about our weight loss program?: ____________________________________

Exercise:

Do you exercise? ☐ Yes ☐ No

If yes, what kind: ____

____

How Often? ☐ Daily ☐ 4-6 times per week ☐ 1-3 times per week

Diet:

Current weight: ________ lbs. Weight one year ago: _________ lbs.

Height: ___________ Age: _____________

Minimum Adult Weight: _________ pounds at age ________

Maximum Adult Weight: _________ pounds at age ________

What was your ideal weight: _________pounds at age ________

What is your current goal weight: __________

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?

☐ Too rigid ☐ Did not satisfy appetite ☐ Too much cooking involved

☐ Cost ☐ Not enough food options ☐ Did not like taste of food

☐ Other: ____

What other methods, if anything, have you tried to lose weight?: (check all that apply)

☐ Exercise ☐ Pills ☐ Fasting ☐ Other: ________________________

Why is it important for you to lose weight? (check all that apply)

☐ Self Esteem ☐ Appearance ☐ Upcoming Event ☐ Tight Clothes

☐ General Health ☐ Doctor's Suggestion ☐ Other: ________________________

FAMILY LIFE:

What is your marital status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No

Number of children: _______________ Ages: __________________________

How often and which meals does your family sit down and eat together? ___________________

____

Will your family/friends help you diet ☐ Yes ☐ No

If not, who will you turn to your support? ____

MEDICAL INFORMATION:

Please list any physicians you see and their specialty:

Dr. ______________________________ Specialty: __________________________________

Dr. ______________________________ Specialty: __________________________________

Dr. ______________________________ Specialty: ___________________________________

Diabetes:

Do you have diabetes? ☐ Yes ☐ No (if no, skip to the 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 III – insulin dependent (diabetic pills and insulin)

Is your blood sugar level monitored? ☐ Yes ☐ No

If so, by whom? ☐ Myself ☐ Physician ☐ Other:______________________

Are you taking medication for your diabetes? ☐ Yes ☐ No

If so, please list: ____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

Cardiovascular Function:

Have you had a cardiovascular event? ☐ Yes ☐ No (if no, skip to the next section)

If so, please specify: ____

How long ago: _______________

Are you currently under the care of a physican for this condidtion? ☐ Yes ☐ No

Are you currently taking any medications for this condidtion? ☐ Yes ☐ No

If so, please list: ____

Do you have a history of arrhythmia? ☐ Yes ☐ No

Have you been diagnosed with Congestive Heart Failure? ☐ Yes ☐ No

Hypertension:

Do you have high blood pressure? ☐ Yes ☐ No (if no, skip to the 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 medication for blood pressure? ☐ Yes ☐ No

If so, please list: ____

Kidney Function:

Have you been diagnosed with kidney disease? ☐ Yes ☐ No

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Have you ever had kidney stones? ☐ Yes ☐ No

Have you ever had gout? ☐ Yes ☐ No

Liver Function:

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

If so, please specify: ____

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Colon Function:

Do you have: ☐ Irritable Bowel ☐ Colitis ☐ Diarrhea ☐ Diverticulosis ☐ Crohn's disease ☐ Constipation

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Stomach/Digestive Function:

Do you have: ☐ Acid Reflux ☐ Gastric Ulcer ☐ Heartburn ☐ Celiac Disease

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Ovarian/Breast Health:

Check off the situations that apply to you currently:

- ☐ Irregular Periods ☐ Menopause ☐ Fibrocystic Breasts
- ☐ Painful Periods ☐ Hysterectomy ☐ Heavy periods
- ☐ Amenorrhea ☐ Uterine Fibroma ☐ Cancer (ovary, uterus, breast)

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

Are you taking medication for this? ☐ 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 so, are you under the care of a physician? ☐ Yes ☐ No

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Mental Health:

Do any of the following apply to you? (if no skip to the next section)

- ☐ Depression ☐ Bulimia (or history of) ☐ Panic Attacks
- ☐ Anxiety ☐ Anorexia (or history of)

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Inflammatory Conditions:

Do any of the following apply to you? (if no skip to the next section)

- ☐ Migraines ☐ Fibromyalgia ☐ Rheumatoid Arthritis
- ☐ Lupus ☐ Osteoarthritis ☐ Chronic Fatigue Syndrome
- ☐ Psoriasis ☐ Other: ______________________________________

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

Are you taking medication for this? ☐ Yes ☐ No

If so, please list: ____

Other Health issues:

Do you have Parkinson's disease? ☐ Yes ☐ No

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 medication for this? ☐ Yes ☐ No

If so, please list: ____________________

General:

Are you generally fatigues or have low energy? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ 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, are you under the care of a physician? ☐ Yes ☐ No

Are you taking any 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.	

Allergies:

Do you have any known 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 serve you

What time do you normally wake up: ____________

Breakfast:

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

Approximate time of day: ____________

Examples: ____________________

____

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

Approximate time of day: ________________

Examples: ____

Lunch:

Do you have **lunch** every afternoon? ☐Yes ☐Sometimes ☐Never

Approximate time of day: ________________

Examples: ____

____

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

Approximate time of day: ________________

Examples: ____

Dinner:

Do you have **dinner** every evening? ☐Yes ☐Sometimes ☐Never

Approximate time of day: ________________

Examples: ____

____

Do you have a **snack** at night? ☐Yes ☐Sometimes ☐Never

Approximate time of day: ________________

Examples: ____

What time do you go to bed: ________________

Other:

Do you prefer: ☐Sweet foods ☐Salty Foods ☐ Fatty Foods

Are you a vegetarian? ☐Yes ☐ No

How many glasses of **water** do you drink per day? ___________ glasses (8 oz glass)

How many cups of **coffee** do you drink per day? ___________ cups

Do you drink soda/pop: ☐Yes ☐ No

If yes, regular or diet: ___________ Servings per day: _________

Do you drink alcohol? ☐Yes ☐ No

If yes, how much and how often? ____

Currently, normal day for me includes approximately __________ calories per day.

How do you reward yourself for dieting/weight loss?: ______________________________________

Where do you usually eat your meals?:

☐ Kitchen ☐Dining Room ☐Living Room ☐ Other: ____________________

Do you take time to plan and cook your meals? ☐Yes ☐ No

Or do you prefer fast food? ☐Yes ☐ No

CASH Scale: **C**ompulsion or **C**raving/**A**ppetite/**S**atiety/**H**unger

Score each item on a 0-19 numbering scale. Each feeling represents a different part of the brain and different neurotransmitter.

Compulsions/Cravings

Feeling the urge to eat when not really 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 | Have one plate | Have seconds | Have a third helping

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 while on our weight loss program. If you stop taking them, you may experience undesirable side effects. __________ (Client's initials)

If you have health issues not indicated on this health profile, please inform our office.

Signature: ____________________________________ Date: ______________________

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to begin a weight loss plan.