Weight Loss Profile

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:____ Phone:_________________

Age: _____ Profession: ______________________ E-Mail: _________________________

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: __________

GOAL WEIGHT: _____ lbs. DESIRED COMPLETION DATE ___________

Do you exercise? ◻ Yes ◻ No

If yes, what kind? ____

____

How often?____

____

In the last 6 months have you had any stiffness, pain or arthritic problems? ◻ Yes ◻ No

where: Neck / Mid back / Low back / Hips / Knees / Foot-Ankle / Shoulder(s) / Arm

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. 10 being the most important): _____________

***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 Function*:**

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

Have you been diagnosed with Congestive Heart Failure (CHF) □ 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 Function:

Have you been diagnosed with kidney disease? ◻ 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:

____

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 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 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 any medication? ◻ 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 any medication? ◻ Yes ◻ No
If so, please list:

____

Ovarian/Breast Function:

Check off the situations that apply to you currently:
◻ Irregular Periods ◻ Menopause ◻ Fibrocystic Breasts
◻ Painful Periods ◻ Hysterectomy ◻ Heavy periods
◻ Amenorrhea ◻ Uterine Fibroma ◻ Cancer (uterus, breast)
If so, are you under the care of a physician? ◻ Yes ◻ No
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? (if no, 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:

____

***Inflammatory Conditions*:**

Do any of the following apply to you? (if no, 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:

____

***General*:**

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 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: ______________________________
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 Medications, Vitamins, Herbs or Supplements Y / N

Medication, Vitamin, Herb or Supplement Names & 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 many glasses of water do you drink per day? __________ glasses

How many cups of coffee do you drink per day? __________ 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 **C**ravings/**A**ppetite/**S**atiety/**H**unger

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 second's 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