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: _____

Age: _____ Profession: _____

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