Weight Loss Profile

Weight Loss 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.

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender: ○ Female ○ Male Age: _____ Profession: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method: ○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Weight: _____ Goal Weight: _____ Desired Completion Date: _____

Minimum Adult Weight: _____ at age: _____

Maximum Adult Weight: _____ at age: _____

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 Shoulders ☐ Arm ☐ Hand/Wrist

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:

_____

Family Life

2. What is your marital status?

○ Married ○ Single ○ Divorced ○ Widowed

Do you have any children?

○ Yes ○ No

Number of children: _____ Age: _____

Medical Information

3. Please list any physicians you see and their specialty:

_____

_____

_____

_____

Diabetes

4. Do you have diabetes?

○ Yes ○ No

5. Are you under the care of a physician?

○ Yes ○ No

Which type of diabetes do you have?

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

○ Type II – Insulin dependent (diabetic pills and insulin injections)

Is your blood sugar level monitored?

○ Yes ○ No

If so, by whom?

○ Myself ○ Physician ○ Other

If other, please specify:

_____

Are you taking any medication?

○ Yes ○ No

6. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

7. Do you tend to be hypoglycemic?

○ Yes ○ No

Cardiovascular Function

8. Have you had a cardiovascular event?

○ Yes ○ No

9. Please specify:

_____

When did it occur?

_____

Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

10. If so, please list:

	Medication	Dosage	Reason for taking
1			
2			
3			

11. Do you have a history of arrhythmia?

○ Yes ○ No

Have you been diagnosed with Congestive Heart Failure (CHF)?

○ Yes ○ No

Hypertension

12. Do you have high blood pressure?

○ Yes ○ No

13. Do you have your blood pressure checked regularly?

○ Yes ○ No

Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

14. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Kidney Function

15. Have you been diagnosed with kidney disease?

○ Yes ○ No

Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

16. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

17. Have you ever had kidney stones?

○ Yes ○ No

Have you ever had gout?

○ Yes ○ No

Colon Function

18. Do you have any of the following?

☐ Irritable Bowel ☐ Colitis ☐ Diarrhea

☐ Diverticulosis ☐ Crohn's Disease ☐ Constipation

☐ None

19. Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

20. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Stomach/Digestive Function

21. Do you have any of the following?

☐ Acid Reflux ☐ Gastric Ulcer ☐ Heartburn

☐ Celiac Disease ☐ None

22. Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

23. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Ovarian/Breast Function

24. Check all that currently apply to you:

☐ Irregular Periods ☐ Hysterectomy ☐ Cancer

☐ Menopause ☐ Heavy Periods ☐ Fibrocystic Breasts

☐ Amenorrhea ☐ Painful Periods ☐ Uterine Fibroma

☐ None

25. Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?
○ Yes ○ No

26. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

27. Please indicate the date of your last menstrual cycle:

_____

Thyroid Function

28. Do you have a thyroid problem?

○ Yes ○ No

29. Are you under the care of a physician?
○ Yes ○ No

Are you taking any medication?
○ Yes ○ No

30. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Emotional Evaluation

31. Do any of the following apply to you?

☐ Depression ☐ Anxiety ☐ Panic Attacks
☐ Anorexia (or history of) ☐ Bulimia (or history of) ☐ None

32. Are you under the care of a physician?
○ Yes ○ No

Are you taking any medication?
○ Yes ○ No

33. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Inflammatory Conditions

34. Do any of the following apply to you?

- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Psoriasis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Other autoimmune or inflammatory condition
- ☐ Rheumatoid Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ None

If other, please specify:

_____

35. Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?

○ Yes ○ No

36. If yes, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

General

37. Do you have Parkinson's disease?

○ Yes ○ No

Do you have cancer?

○ Yes ○ No

Are you in cancer remission?

○ Yes ○ No

If so, for how long?

_____

Are you under the care of a physician?

○ Yes ○ No

Are you taking any medication?
○ Yes ○ No

38. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

39. 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:

Are you under the care of a physician?
○ Yes ○ No

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

40. If so, please list:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Allergies

41. Do you have any FOOD allergies?

○ Yes ○ No

42. If so, please list:

	Allergic to?	Reaction
1		
2		
3		

43. Do you have any MEDICATION allergies?

○ Yes ○ No

44. If so, please list:

	Allergic to?	Reaction
1		
2		
3		

45. Are you currently taking medications, vitamins, herbs, or supplements?

○ Yes ○ No

46. If so, please list and give the reason for taking it:

	Medication	Dosage	Reason for taking?
1			
2			
3			

Eating Habits

Please be as honest as possible so that we may better help you.

47. Breakfast

Do you have breakfast every morning?

○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

Do you have a snack before lunch?

○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

48. Lunch

Do you have lunch every day?
○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

Do you have a snack before dinner?
○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

49. Dinner

Do you have dinner every day?
○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

Do you have a snack at night?
○ Always ○ Sometimes ○ Never

Approximate time:

_____

Examples:

_____

50. Other

Do you prefer:
○ Sweet foods ○ Salty foods ○ Fatty foods

Are you a vegetarian?
○ Yes ○ No

How many glasses of WATER do you drink in a day? _____

How many cups of COFFEE do you drink in a day? _____

Do you smoke?
Yes No

If yes, how many packs per day? For how many years?

Do you drink alcohol?
Yes No

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

Do you have any interest in the following programs?

51. Chiropractic Care
Neuropathy Symptom Treatment

CASH Scale

Compulsions/**C**ravings **A**ppetite **S**atiety **H**unger

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

52.

	0	1	2	3	4	5	6	7	8	9	10
Compulsions/Cravings - Feeling or urge to eat when not hungry. You are full and there is no food in sight yet you get an urge to eat which cannot be repressed.	Never occurs										Constant
Appetite - Feeling of hunger stimulated by sight, sounds, smells, or social cues. Imagine this scenario: you recently ate and feel full. You walk into a room and there is food everywhere. It looks and smells good and everyone is having fun. You:	Never eat more										Always eat more
Satiety - A feeling of fullness acquired during eating. When you eat, you usually:	Leave food on plate			Eat one plate				Have seconds			Have thirds
Hunger - That feeling of a pain or ache in your stomach when it is really empty. This is a true pain or discomfort.	Never hungry										Constant hunger

Patient Quality of Life Survey

53. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Email Address: _____

54. Please take several minutes to answer these questions so we can help you get better. (Please choose as many that apply)

1. How have you taken care of your health in the past?

☐ a. Medications ☐ b. Emergency Room
☐ c. Routine Medical ☐ d. Exercise
☐ e. Nutrition/Diet ☐ f. Holistic Care ☐ g. Vitamins
☐ h. Chiropractic ☐ i. Other (please specify):

If other, please specify: _____

2. How did the previous method(s) work out for you?
☐ a. Bad results ☐ b. Some results ☐ c. Great results ☐ d. Nothing changed ☐ e. did not get worse
☐ f. did not work very long ☐ g. Still trying ☐ h. Confused

3. How have others been affected by your health condition?
☐ a. No one is affected ☐ b. Haven't noticed any problem ☐ c. They tell me to do something
☐ d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
☐ a. Job ☐ b. Kids ☐ c. Future ability ☐ d. Marriage ☐ e. Self-esteem ☐ f. Sleep ☐ g. Time ☐ h. Finances
☐ i. Freedom

5. Are there conditions you are afraid this might turn into?
☐ a. Family health problems ☐ b. Heart disease ☐ c. Cancer ☐ d. Diabetes ☐ e. Arthritis
☐ f. Fibromyalgia ☐ g. C ☐ h. Depression ☐ i. Freedom

6. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

7. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

_____

_____

8. What are you most concerned with regarding your problem?

_____

9. Where do you picture yourself being in the next 1-3years if this problem is not taken care of? Please be specific.

_____

_____

10. What would be different/better without this problem? Please be specific.

_____

_____

11. What do you desire most to get from working with us?

_____

12. What would that mean to you?

_____

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

55. Please enter your information.

First Name:	Middle Initials:	Last Name:	Date of Birth:
_____	_____	_____	_____

Email Address:

_____

56. Let's get started. Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
☐ Headaches and migraines

Hormone imbalance including:
☐ PMS ☐ Emotional imbalance

Gastrointestinal issues including:
☐ Abdominal bloating and cramps or painful gas ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis
☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
☐ Chronic sinusitis ☐ Asthma ☐ Allergies

Autoimmune Conditions including:
☐ Diabetes Mellitus ☐ Lupus ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Chronic Fatigue

Developmental and social concerns including:
☐ Austism ☐ ADD/ADHD

Skin Conditions: (urticaria)
☐ Eczema ☐ Skin rashes ☐ Hives

57. Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

	None	Mild	Moderate	Severe
Constipation and/or diarrhea				
Abdominal pain or bloating				
Mucous or blood in stool				
Joint pain or swelling, arthritis				
Chronic or frequent fatigue or tiredness				
Food allergies, sensitivities or intolerance				
Sinus or nasal congestion				
Chronic or frequent inflammations				
Eczema, skin rashes or hives (urticaria)				
Asthma, hayfever, or airborne allergies				
Confusion, poor memory or mood swings				
Use of NSAIDS (Aspirin, Tylenol, Motrin)				
History of antibiotic use				
Alcohol consumption makes you feel sick				
Ulcerative colitis or celiac's disease				
Nausea				
Weight Trouble				

58. Total:

_____