



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: _____

Phone: _____ Cell: _____ E-mail: _____

Date of Birth: _____ 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: _____

Do you exercise? Yes No

If yes, what kind?

How often?

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): _____

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 (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 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

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: 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: 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:

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 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 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 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 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

