

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.

<u>General</u>			
Last Name:		First Name:	
Address:	Apt/Unit: #		.pt/Unit: #
City:		State:	Zip:
Phone:	Cell:		E-mail:
Date of Birth:	Age:	Profession:	
Whom may we thank for re	eferring you?		
Weight:lbs. Weight 1 Maximum Weight:			
Do you exercise? If yes, what kind?			
How often?			
Have you been on a diet be If yes, please specify which too much cooking involved	n diet and why you , etc.):	think it didn't w	ork for you (e.g. too rigid,

<u>Family Life</u> :			
What is your marital status? M S D W Number of children: Ages:	Do you	have	children? - Yes - No
<u>Medical Information</u> :			
Please list any physicians you see and their	specialt	y:	
<u>Diabetes</u> :			
Do you have diabetes? $\ \square$ Yes $\ \square$ No (if no,	skip to n	ext sec	tion)
If so, are you under the care of a physician?	? 🗆 Yes	□ No)
If so, which type?			
$\hfill\Box$ Type I \hfill insulin dependent (ins	ulin inje	ctions	only)
□ Type II – non-insulin dependent	t (diabe	tic pills	5)
□ Type II – insulin dependent (dia	abetic pi	lls and	insulin)
Is your blood sugar level monitored? — Ye If so, by whom? — Myself — Physician —			y):
Are you taking any medication? Yes Results No.	0		
Do you tend to be hypoglycemic?	□ Yes	□ No	
<u>Cardiovascular Health</u> :			
Have you had a cardiovascular event? If so, please specify:	□ Yes	□ No	(if no, skip to next section)
How long ago?			
If so, are you under the care of a physician? Are you taking any medication? If so, please list:	? - Yes	□ No □ No	
Do you have a history of arrhythmia	□ Yes	□ No	
<u>Hypertension</u> :			
Do you have high blood pressure? If so, do you have your blood pressure chec If so, are you under the care of a physician? Are you taking any medication?		YesYesYesYes	□ No (if no, skip to next section□ No□ No□ No

Kidney Health: Have you been diagnosed with kidney disease? If so, are you under the care of a physician? Are you taking any medication? If so, please list:	 Yes □ No (if no, skip to next section) Yes □ No Yes □ No
Have you ever had Gout?	□ Yes □ No
Liver Health:	
Do you have liver problems? If so, please specify:	\square Yes \square No (if no, skip to next section)
If so, are you under the care of a physician?	□ Yes □ No
Are you taking any medication? If so, please list:	□ Yes □ No
Colon Health: Do you have: Crohn's disease Constipation If so, are you under the care of a physician? Are you taking any medication? If so, please list:	
Stomach/Digestive Health:	
	Heartburn 🛮 Celiac Disease?
If so, are you under the care of a physician? Are you taking any medication? If so, please list:	□ Yes □ No □ Yes □ No
Ovarian/Breast Health:	
□ Painful Periods □ Hysterectomy □ He	ly: procystic Breasts eavy periods incer (uterus, breast)
Please indicate the date of your last menstrual cy	cle:

Thyroid Function:		
Do you have thyroid problems?	Yes □ No (if no, skip to next	section)
, ,	Yes □ No	
Are you taking any medication?	Yes □ No	
Emotional Evaluation:		
Do any of the following apply to you? (if no, skip to a Depression — Anxiety — Panic Attac		
□ Bulimia (or history of) □ Anorexia (o	, ,	
, ,	Yes □ No	
Are you taking any medication?	Yes □ No	
<u>Inflammatory Conditions</u> :		
Do any of the following apply to you? (if no, skip to r		
□ Migraines□ Fibromyalgia□ Rheumatoid Artl□ Osteoarthritis	nritis 🗆 Lupus	
□ Chronic Fatigue Syndrome □ Psoriasis		
□ Other autoimmune or inflammatory condition:		
, ,	Yes □ No	
Are you taking any medication?	Yes □ No	
11 30, piedse list.		
General:		
,	□ Yes □ No	
,	□ Yes □ No	
If so, please specify and indicate for how long:	- Voc No	
, ,	□ Yes □ No □ Yes □ No	
If so, please list:		
Are you generally fatigued or have low energy?	□ Yes □ No	
Are you prograpt? - Vos - No Are you	breastfeeding?	- No
Are you pregnant? Yes No Are you	breastreeding: 1 Tes	□ No
Do you get cold easily? Yes No Do you ha	ve cold hands/feet?	□ No
Do you have other health problems? If so, please specify:	□ Yes	□ No
If so, are you under the care of a physician?	□ Yes	□ No
Are you taking any other medications not listed about f so, please list:	ve? Yes	□ No

Are you currently taking Vitamins, Herbs of Vitamin, Herb or Supplement 1.	nt Name Reason	□ Yes □ No on
2		
3		
4 5		
Allergies:		
Do you have any food allergies? If so, please list:		□ Yes □ No
Do you have any medication allergies? If so, please list:	□ Yes □ No	
<u>Eating Habits</u> : (please be as honest as p	possible so that we may better h	elp you)
Do you have breakfast every morning? Approximate Time: Examples:		
Do you have a snack before lunch? Approximate Time: Examples:	□ Yes □ Sometimes □ Nev	rer
Lunch Do you have lunch every day? Approximate Time: Examples:	□ Yes □ Sometimes □ Nev	⁄er
Do you have a snack before dinner? Approximate Time: Examples:		
Dinner Do you have dinner every day? Approximate Time: Examples:	□ Yes □ Sometimes □	
Do you eat a snack at night? Approximate Time: Examples:	□ Yes □ Sometimes □	Never

Other: Do you prefer: Sweet foods Are you a vegetarian? How many glasses of water do you drink How many cups of coffee do you drink Do you smoke? If yes, how many packs per day? Do you drink alcohol? If yes, what, how much, and how ofte	□ Yes □ No ink per day? ⟨ per day? □ Yes □ No for how many yrs □ Yes □ No	glasses cups ?
CASH Scale: C ompulsions or C raving Score each item on a 0—10 numbering the brain and different neurotransmitted.	ng scale. Each feeling	_
<u>Compulsions/Cravings</u> Feeling or urge to eat when not hungr an urge to eat which cannot be repres	•	is no food in sight. You get
0123 Never occurs	4567	-8910 Constant
Appetite Feeling of hunger stimulated by sight, and feel full. You walk into a room. The Everyone is having fun. You:		•
033		-8910 lways eat more
Satiety A feeling of fullness acquired during e	ating. When you eat, y	you usually:
0134 Leave food on plate one plate or		
<u>Hunger</u>		

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

Loss Method. If you stop taking them, you may effects (Client's initials)	
If you are taking medications, are you interested in your prescription medications? $\ \square$ Yes $\ \square$ No	getting off of any or all of
If you have health problems not indicated on this h your physician.	ealth profile, please consult
Signature: Date:	

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.