



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.

General

Last Name: _____ First Name: _____

Age: _____ Profession: _____ Phone Number: _____

Email: _____

How did you hear about us? _____

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? (Circle all that apply) 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

What is your marital status? M S D W Do you have any 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 Cardiovascular Function)

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 (please 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 Hypertention)

Please specify: _____

When did it occur? _____

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 Kidney Function)

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

If so, please list: _____

Kidney Function

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

If so, please list: _____

Have you ever had kidney stones? Yes No

Have you ever had gout? Yes No

Colon Function

Do you have any of the following? (Select all that apply):

- Irritable Bowel Colitis Diarrhea Diverticulosis
 Crohn's Disease Constipation None (If none, skip to Stomach/Digestive)

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 any of the following? (Select all that apply):

- Acid Reflux Gastric Ulcer Heartburn Celiac Disease
 None (if none, skip to Ovarian/Breast Function)

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 all that currently apply to you:

- Irregular Periods Menopause Fibrocystic Breasts Painful Periods
 Hysterectomy Heavy Periods Amenorrhea Uterine Fibroma
 Cancer None (If none, skip to Thyroid Function)

Are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If yes, please list: _____

Please indicate the date of your last menstrual cycle: _____

Thyroid Function

Do you have a thyroid problem? Yes No (If no, skip to Emotional Evaluation)

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? (Select all that apply):

Depression Anxiety Panic Attacks Bulimia (or history of)

Anorexia (or history of) None (If none, skip to Inflammatory Conditions)

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? (Select all that apply):

Migraines Fibromyalgia Rheumatoid Arthritis Osteoarthritis

Lupus Chronic Fatigue Syndrome Psoriasis None (if none, skip to General)

Other autoimmune or inflammatory condition (Please specify):

Are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If yes, 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, for how long? _____

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: _____

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: _____

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: _____



Are you currently taking medications, vitamins, herbs, or supplements? Yes No

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

Eating Habits

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

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: _____

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: _____



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: _____

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? _____



CASH Scale

Compulsions/Cravings

Appetite

Satiety

Hunger

Score each item on a scale of 0-10. 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 and there is no food in sight yet 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. 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:

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			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.

0	1	2	3	4	5	6	7	8	9	10
Never Hungry									Constant Hunger	