CHIRO-MED

Excellence in Chiropractic Medicine

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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, how committed are you to losing fat on this program? (10 being the highest level of commitment): ____________________________

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:

____

____

____

____

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:____
List all medications for allergies on back sheet.

Cardiovascular Function:

Have you had a cardiovascular event? ❑ Yes ❑ No (if no, check box and 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
List all medications for cardiovascular function on back sheet.
Do you have a history of arrhythmia ❑ Yes ❑ No
Have you been diagnosed with Congestive Heart Failure (CHF) ❑ Yes ❑ No

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
List all medications for colon function on back sheet.

Diabetes:

Do you have diabetes? ❑ Yes ❑ No (if no, check box and 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
List all medications for diabetes on back sheet.
Do you tend to be hypoglycemic? ❑ Yes ❑ No

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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for emotional conditions on back sheet.

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 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 medications for any of the above? ❑ Yes ❑ No

List all medications for the above on back sheet.

Hypertension:

Do you have high blood pressure? ❑ Yes ❑ No (if no, check box and 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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for hypertension on back sheet.

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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for inflammatory conditions on back sheet.

Kidney Function:

Have you been diagnosed with kidney disease? ❑ Yes ❑ No (if no, check box and skip to next section)
If so, are you under the care of a physician? ❑ Yes ❑ No
Are you taking any medication? ❑ Yes ❑ No
List all medications for kidney function on back sheet.
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, check box and 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
List all medications for liver function on back sheet.
If so, are you under the care of a physician? ❑ Yes ❑ No
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for liver function on back sheet.

Muscular/Skeletal Conditions:

In which areas do you have aches or pains:
❑ Neck ❑ Back ❑ Knees ❑ Other ______________________________
How often do you take Ibuprofen or other pain reducing medications for the above? __________
List all medications for muscular/skeletal conditions on back sheet.
Do you have arthritis? If so, where? ______________________________
Are you under the care of a physician for your aches and pains? ❑ Yes ❑ No
Do you feel your weight has damaged or "worn down" any of your joints? ❑ Yes ❑ No

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 taking any medication? ❑ Yes ❑ No
List all medications for ovarian/breast function on back sheet.
Please indicate the date of your last menstrual cycle: ______________________________

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
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for stomach/digestive function on back sheet.

Thyroid Function:

Do you have thyroid problems? ❑ Yes ❑ No (if no, check box and skip to next section)
If so, are you under the care of a physician? ❑ Yes ❑ No
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for thyroid function on back sheet.

Are you currently taking Vitamins, Herbs or Supplements? ❑ Yes ❑ No

Vitamin, Herb or Supplement Name	Reason
1.	
2.	
3.	
4.	
5.	

Eating Habits: (please be as honest as possible so that we may better help you)

Breakfast

Do you have **breakfast** every morning? ❑ Yes ❑ No ❑ Never

Approximate Time:________________

Examples: ____

____

Do you have a **snack** before lunch? ❑ Yes ❑ No ❑ Never

Approximate Time:________________

Examples: ____

____

Lunch

Do you have **lunch** every day? ❑ Yes ❑ No ❑ Never

Approximate Time:________________

Examples: ____

____

Do you have a **snack** before dinner? ❑ Yes ❑ No ❑ Never

Approximate Time:________________

Examples: ____

____

Dinner

Do you have **dinner** every day? ❑ Yes ❑ No ❑ Never

Approximate Time:________________

Examples: ____

____

Do you eat a **snack** at night? ❑ Yes ❑ No ❑ 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: *C*ompulsions 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/Cravinqs

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

You must take vitamins and minerals while you are on the Chiro-Med Weight Loss Program. If you stop taking them, you may experience undesirable side effects.________________ (Client's initials)

If you are taking medications, are you interested in getting off of any or all of your prescription medications? ☐ Yes ☐ No

If you have health problems not indicated on this health profile, please consult your physician.

Obesity affects entire families. Do you have any family members who could benefit from this program? ☐ Yes ☐ No

Please list all medications which you take on back side of this page.

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 Chiro-Med Weight Loss Program.

You must talk to Dr. Laux prior to starting this diet if you have a history of any of the following:

- History of a cardio-vascular event: (i.e. heart attack, stroke, aneurysm, by-pass, stent surgery, history of having cardiac arrhythmia including have a pace-maker)
- History of or current active cancer; including skin cancers
- Pregnant female (note from OB/GYN ONLY)
- Breast-feeding female (note from PEDIATRICIAN ONLY)
- Severe Liver Disease
- Severe Kidney Disesase
- Diagnosis or history of Congestive Heart Failure (CHF)
- Patients currently on Lithium therapy
- Patients with a diagnosis of Parkinson's Disease
- Strict Vegan lifestyle

MEDICATIONS

Please list all medications taken for the following:

Allergies: ______________________________

Cardiovascular function: ______________________________

Colon function: ______________________________

Diabetes: ______________________________

Emotional conditions: ______________________________

General medications: ______________________________

Hypertension: ______________________________

Inflammatory conditions: ______________________________

Kidney function: ______________________________

Liver function: ______________________________

Muscular/skeletal conditions: ______________________________

Ovarian/breast function: ______________________________

Stomach/digestive function: ______________________________

Thyroid function: ______________________________

For Office Use Only

First Appointment

- ☐ *Photo*
- ☐ *Weight* ______________________________
- ☐ *BMI* ______________________________

Vitals

- ☐ *Blood Pressure* ______________________________
- ☐ *Pulse* ______________________________

Final Appointment

- ☐ *Photo*
- ☐ *Weight* ______________________________
- ☐ *BMI* ______________________________

Vitals

- ☐ *Blood Pressure* ______________________________
- ☐ *Pulse* ______________________________

"If you follow the program it works. It's the easiest diet I've ever been on."

-Mark Wachtel (lost 227 lbs. in 50 weeks)