

CHIRO-MED

Excellence in Chiropractic Medicine

3200 WEST MAIN STREET
BELLEVILLE, IL 62226
618-235-3200 • Fax 618-235-3282
E-mail: chiromed1@aol.com

1480 NORTH GREEN MOUNT RD.
O'FALLON, IL 62269
618-622-2222 • Fax 618-624-8357
E-mail: chiromedofallon@sbcglobal.net

www.chiromedltd.com

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: 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

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 Disease
- 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)