CHIRO-MED WEIGHT LOSS
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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:_____

Cell: _____Phone: _____ E-mail: _____

Date of Birth: _____ Age: _____ Profession: _____

Whom may we thank for referring you? _____

Current Weight: _____ Weight 1 year ago: _____

Minimum Adult Weight: _____lbs at age _____

Maximum Adult Weight: _____lbs at age _____

Do you exercise? ❑ No ❑ Yes 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? Married Single Divorced Widow Do you have children?_____
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 the last page labeled Medications.

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 the last page labeled Medications.
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 the last page labeled Medications.

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 the last page labeled Medications..
Do you tend to be hypoglycemic? ❑ Yes ❑ No

Emotional Evaluation:

Do any of the following apply to you? (if no, check box and 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

List all medications for emotional conditions on the last page labeled Medications.

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 of have low energy? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No

Do you easily get cold? ❑ 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 medication? ❑ Yes ❑ No

List all medications on the last page labeled Medications.

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

Are you taking any medication? ❑ Yes ❑ No

List all medications for hypertension on the last page labeled Medications.

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 of inflammatory condition:_____

_____

If so, are you under the care of a physician? ❑ Yes ❑ No

Are you taking any medication? ❑ Yes ❑ No

List all medications for inflammatory conditions on the last page labeled Medications.

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 the last page labeled Medications.

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 the last page labeled Medications.

Muscular/Skeletal Conditions:

In which areas do you have aches or pains?

❑ Neck ❑ Back ❑ Knees ❑ Other_____

How often do you take medications for the above? :_____

Do you have arthritis? If so, where? :_____

Are you under the care of a physician for any of your aches and pains? ❑ Yes ❑ No

Do you feel your weight has damaged or "worn down" any of your joints? ❑ Yes ❑ No

List all medications for muscular/skeletal conditions on the last page labeled Medications.

Ovarian/Breast Function:

Check off the conditions that currently apply to you? (if none, skip to next section)

❑ Irregular Periods ❑ Menopause ❑ Fibrocystic Breasts

❑ Painful Periods ❑ Hysterectomy ❑ Heavy Periods

❑ Amenorrhea (no period) ❑ Uterine Fibroma ❑ Cancer (breast/uterine)

If so, are you under the care of a physician? ❑ Yes ❑ No

Are you taking any medication? ❑ Yes ❑ No

Please indicate the date of your last menstrual cycle:_____

List all medications for ovarian/breast function on the last page labeled Medications.

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

Are you taking any medication? ❑ Yes ❑ No

List all medications for stomach/digestive function on the last page labeled Medications.

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

Are you taking any medication? ❑ Yes ❑ No

List all medications for thyroid function on the last page labeled Medications.

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

Name **Reason**

1._____

2. _____

3._____

4._____

5._____

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

If you have any health problems/concerns 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

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.

MEDICATIONS

Please list all medications taken for the following:

Allergies: _____
_____
_____

Inflammatory Conditions: _____
_____
_____

Cardiovascular Function: _____
_____
_____

Kidney Function: _____
_____
_____

*Colon Function:*_____
_____
_____

Liver Function: _____
_____
_____

*Diabetes:*_____
_____
_____

Muscular/Skeletal Conditions: _____
_____
_____

*Emotional Conditions:*_____
_____
_____

Ovarian/Breast Function: _____
_____
_____

*General Medications:*_____
_____
_____

Stomach/Digestive Function: _____
_____
_____

*Hyptertension:*_____
_____
_____

Thyroid Function: _____
_____
_____

For Office Use Only

First Appointment

❑Photo
❑Weight _____
❑BMI _____

Final Appointment

❑Photo
❑Weight _____
❑BMI _____

"If you follow the program it works. It's the easiest diet I've ever been on. "
-Mark W. (lost 227 lbs. in 50 weeks)