blueprint to Weight Loss

# 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? _____

Address:_____

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:_____

blueprint to Weight Loss

## 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:_____

blueprint to Weight Loss

## 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

**C**ompulsions/**C**ravings **A**ppetite **S**atiety **H**unger

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 |

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Dr. J.H. Rodriguez DC

## Patient Quality Of Life Survey

**Name:** _____ **Date:** _____

*Please take several minutes to answer these questions so we can help you get better.*
***(Please circle as many that apply)***

1. How have you taken care of your health in the past?
   - a. Medications
   - b. Emergency Room
   - c. Routine Medical
   - d. Exercise
   - e. Nutrition/Diet
   - f. Holistic Care
   - g. Vitamins
   - h. Chiropractic
   - i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   - a. Bad results
   - b. Some results
   - c. Great results
   - d. Nothing changed
   - e. Did not get worse
   - f. Did not work very long
   - g. Still trying
   - h. Confused

3. How have others been affected by your health condition?
   - a. No one is affected
   - b. Haven't noticed any problem
   - c. They tell me to do something
   - d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - a. Job
   - b. Kids
   - c. Future ability
   - d. Marriage
   - e. Self-esteem
   - f. Sleep
   - g. Time
   - h. Finances
   - i. Freedom

5 Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

**How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

**What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:**

**What are you most concerned with regarding your problem?**

**Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific**

**What would be different/better without this problem? Please be specific**

**What do you desire most to get from working with us?**

**What would that mean to you?**