Greenspan Wellness Center
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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:_____

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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:_____

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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/**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