

What is the date of the information session you attended?
Which Transformations location do you plan on attending? Savoy Monticello
Have you had labs (lipid profile & basic metabolic panel) done within 6-12
months? 🗆 I don't know
Yes at Christie Clinic Other
By checking the box for Christie, you are giving Christie Clinic's Transformations team permission to
access your records.
(If "Other", please fill out our permission form OR fax recent labs to us)
\Box No I will get them from my physician outside of Christie Clinic and send them to you.
Fax No. is 366-7469
No Please order them for me at Christie Clinic.
When do you want to get started with the diet?
Do you prefer a Saturday for your appointment? YES NO

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.

MEDICATION LIST IS MANDATORY! PLEASE ATTACH TO THE BACK FROM PHYSICIAN.

Last Name:		First Name:
Address:		Apt/Unit: #
City:	State:	Zip:
Home Phone:	Cell:	Work Phone:
E-mail:	Profession:	Employer:
Date of Birth:	Age:	What are your goals?

On a scale of 1 to 10, indicate what level of importance do you give to losing weight via the Transformations medically supervised weight loss method (10 being the most important):_____

If your your ranking is < 10, let us know what you need to do to increase that number?

How did you hear about Transformations? (Please check all that apply)
Brochure , which I picked up from Radio ad
Facebook Transformations Website Referral from my physician, who?
Referred from another dieter, if so who?
Other, please specify
Please Answer Weight:lbs. Weight 1 year ago:lbs. Min. Adult Weight:lbs.
at age Maximum Weight:Ibs. at age Height:
Do you exercise? Yes No
If yes, what kind?
How often and at what intensity?
Have you been on a diet before?
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.):
Family Life: What is your marital status? M S D W Do you have children? Yes □ No Number of children: Ages: Do you live alone? □ Yes □ No No If no, does he/she know you are starting this program? □ Yes □ No
Medical Conditions Please Check "No" if it does not apply to you.
Do you experience shortness of breath with daily activities? Yes No (expand with comments)
Do you use a C-PAP machine?
Have you had recent weight loss or weight gain? Yes No (please specify)
<u>Diabetes</u> : Do you have diabetes? □ Yes □ No (if No, 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):

Do you tend to have low blood sugar?	□ No	
Cardiovascular Health:		
Have you had any cardiac problems?	🗆 Yes	🗆 No
If so, please specify (heart attack, stroke, heart failure,	stents, etc):	
How long ago?		
If so, are you under the care of a physician?	🗆 Yes	□ No
Do you have a history of rhythm problems?	🗆 Yes	□ No
<u>Hypertension</u> :		
Do you have high blood pressure?	🗆 Yes	\Box No (if no, 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
Kidney Health:		
Have you been diagnosed with kidney disease?	Yes	\Box No(if no, skip to next section)
If so, are you under the care of a physician?	🗆 Yes	□ No
Have you ever had Gout?	□ Yes	□ No
<u>Liver Health:</u>		
Do you have liver problems?	🗆 Yes	\Box No (if no, skip to next section)
IF so, please specify:		
If so, are you under the care of a physician?	🗆 Yes	□ No
<u>Colon Health</u>		
Do you have: \Box None of these (if none, skip to next set	ection) Irrit	able Bowel 🛛 Colitis
Diarrhea	🗆 Cro	ohn's disease 🗆 Constipation
If so, are you under the care of a physician?	Yes	□ No
Stomach/Digestive Health:		
Do you have: □ None of these (if none, skip to next s □Heartburn □ Celiac Disease?	section) \Box	Acid Reflux 🗆 Gastric Ulcer
If so, are you under the care of a physician?	□ Yes	□ No
<i>Ovarian/Breast Health:</i> Check off the situations that apply to you currently:	None (skin t	o next section)
□ Irregular periods □ Menopause	Fibrocy	vstic Breasts
□ Painful Periods □ Hysterectomy	Heavy	periods
□ Amenorrhea □ Uterine fibroma	Cancer	· (uterus, breast)
Using Contraceptives/Birth Control		
If so, what kind?		
Are you under the care of a physician?		
Please indicate the date of your last menstrual cycle: _		
Thyroid Function		
Do you have thyroid problems?	□ Yes	\Box No (if no, skip to next section)

If so, are you under the care of a physician?	□ Yes □ No
Emotional Assessment Do any of the following apply to you? None of the Depression Anxiety Bulimia (or history of) Anorexia (or If so, are you under the care of a physician or thera Relevant Notes:	□ Panic Attacks r history of) □ Self Harm apist? □ Yes □ No
Lung/Breathing Problems	
Do any of the following apply to you? □ No □ Migraines □ Fibromyalgia □ Osteoarthritis □ Chronic Fatigue Syndrome □ Other autoimmune or inflammatory condition If so, are you under the care of a physician?	one of these (if none, skip to next section) Rheumatoid Arthritis Lupus Psoriasis Yes No
Bone and Joint Do you currently experience any of the following: Neck pain Arm pain Thigh or leg pain Elbow, wrist, knee or and the following in the	fid back or low back pain \Box Hip pain
Cancer Do you have cancer? Are you in cancer remission? If so, please specify and indicate for how long: If so, are you under the care of a physician? Other Are you generally fatigued or have low energy? Are you pregnant? Yes Do you get cold easily? Yes No Have you been diagnosed with sleep apnea? If so, please specify: (Cholesterol Issues, recent su	I Yes □ No
If so, are you under the care of a physician? Are you currently taking Vitamins, Herbs or Supple <u>Vitamin, Herb or Supplement Name</u> 1.	<u>Reason</u>
2 3 4.	
T .	

<u>Allergies</u> Do you have any food allergies? If so, please list:	□ Yes	🗆 No	
Do you have any medication allergies? If so, please list:	□ Yes	🗆 No	
<u>Eating Habits</u> (please be as honest as p	oossible so that w	ve may better help yo	pu)
Breakfast Do you have breakfast every morning? Approximate Time: Examples:	□ Yes	□ Sometimes	□ Never
Do you have a snack before lunch? Approximate Time: Examples:	□ Yes	□ Sometimes	□ Never
Lunch Do you have lunch every day? Approximate Time: Examples:	□ Yes	Sometimes	□ Never
Do you have a snack before dinner? Approximate Time: Examples:	□ Yes	□ Sometimes	□ Never
Dinner Do you have dinner every day? Approximate Time: Examples:			
Do you eat a snack at night? Approximate Time: Examples:	□ Yes	□ Sometimes	
<u>Other</u> Do you prefer: □ Sweet foods □ Salt Are you a vegetarian? □ Yes □ No How much pop do you consume per day? How many glasses of <u>water</u> do you drink How many cups of <u>coffee</u> do you drink pe	? per day?	Glasses	Decaffeinated Cups

Do you <u>smoke</u> ? 🛛 Yes 🗆 No	
If yes, how many packs per day?	For how many years?
Do you drink <u>alcohol</u> ?	🗆 Yes 🛛 No
If yes, what, how much, and how often?	

What will be the hardest thing for you to give up? (No alcohol, no bread, starch, fruit, dairy)

Are you an emotional eater?
Ves No

lf	no,	how	do	vou	manage	stress?	
				,			

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------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:

Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

<u>Hunger</u>

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

0-----1-----2------3------5-----6-----7-----8------9------10 Never hungry Constant hunger If you are taking medications, are you interested in getting off any or all of your prescription medications?

I agree to use the Ideal Protein foods, vitamins and minerals purchased from the Transformations Clinic while you are on the Ideal Protein Weight-Loss Method. Failure to comply with this purchase agreement could lead to undesirable health side effects and dismissal from the Transformations program.

(Client's initials)

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 Ideal Protein Weight Loss Method.

 Signature:
 Date:

Client Please list any relevant notes for our provider and or health coach, including if you have done the program before please provide some details about your first experience :

Who is your primary care physician? Please also list any other specialty doctors you may have:

Physician Name

Address

Phone # and or Fax #

Medications - please fill out the following chart if you are on less than 2 medications.

If you are on more than two PLEASE ATTACH YOUR MEDICATION LIST. (include medical & psychotropic meds)

Name of Medication	How many mg is each table?*	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500mg	1	1x a day	Dr. John Doe	Omega 3

*or mEq or dosage your doctor prescribes.

Please list 12 reasons why you want to do this program, including the reasons why you want to lose the weight and lead a healthy lifestyle.

1.	
	·
11.	
12.	

Many of us have several reasons why losing weight is important. Keep these 12 things handy and review them periodically or when you may feel you need a reminder. Remembering why we are doing something can be very helpful.

"There is no such thing as I can't. If there's a will, there's a way!"