

What is the date of the information session you attended? \_\_\_\_\_

Which Transformations location do you plan on attending? Urbana or Danville

Are you a Christie registered patient?  Yes  No

Have you had labs (lipid profile & basic metabolic panel) done within 6-9 months?

- I don't know  
 Yes at Christie Clinic  Yes at Presence Covenant Champaign  
 Yes at Carle  Other \_\_\_\_\_

By checking the boxes for Christie, Carle, or Presence (Champaign only), you are giving Christie Clinic's Transformations team permission to access your records at those facilities.

**(If "Other", please fill out our permission form OR fax recent labs to us)**

- No **I will get them from my physician outside of Christie Clinic and send them to you.**  
 No **Please order them at Christie Clinic**

When do you want to get started with the diet? \_\_\_\_\_

### 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: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Profession: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

How did you hear about Transformations? (Please check all that apply)

- Referral from my physician \_\_\_\_\_  Brochure  Radio ad  
 TV  Web site/Google  Referred from another dieter \_\_\_\_\_  
 Other \_\_\_\_\_

**Please Answer** Weight: \_\_\_\_\_ lbs. Weight 1 year ago: \_\_\_\_\_ lbs. Min. Adult Weight: \_\_\_\_\_ lbs.  
 at age \_\_\_\_\_ Maximum Weight: \_\_\_\_\_ lbs. at age \_\_\_\_\_ Height: \_\_\_\_\_

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

Do you exercise?     Yes     No

If yes, what kind? \_\_\_\_\_

How Often and at what intensity? \_\_\_\_\_

**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.): \_\_\_\_\_

**Family Life:**

What is your marital status?    M    S    D    W    Do you have children?     Yes     No

Number of children: \_\_\_\_\_    Ages: \_\_\_\_\_

**Medical Conditions**

**Diabetes:**

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?**     Yes     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

**Hypertension:**

Do you have high blood pressure?     Yes     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  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

**Liver Health:**

Do you have liver problems?  Yes  No (if no, skip to next section)  
If so, please specify: \_\_\_\_\_  
If so, are you under the care of a physician?  Yes  No

**Colon Health**

Do you have:  None of these (if none, skip to next section)  Irritable Bowel  Colitis  
 Diarrhea  Diverticulosis  Crohn'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 section)  Acid Reflux  Gastric Ulcer  
 Heartburn  Celiac Disease?  
If so, are you under the care of a physician?  Yes  No

**Ovarian/Breast Health:**

Check off the situations that apply to you currently:  None (skip to next section)

- Irregular periods  Menopause  Fibrocystic 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  No (if no, skip to next section)  
If so, are you under the care of a physician?  Yes  No

**Emotional Evaluation**

Do any of the following apply to you?  None of these (if none, 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

Relevant Notes: \_\_\_\_\_

**Lung/Breathing Problems**

If so please specify:

\_\_\_\_\_  
\_\_\_\_\_

**Do any of the following apply to you?**  None of these (if none, 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

**Bone and Joint**

Do you currently experience any of the following:  None of these (if none, skip to next section)

- Neck pain       Arm pain       Mid back or low back pain       Hip pain  
 Thigh or leg pain       Elbow, wrist, knee or ankle pain       Headaches

**Cancer**

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

**Other**

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

**Have you been diagnosed with sleep apnea?**  Yes  No

**Do you have other health problems?**  Yes  No

If so, please specify: (Cholesterol Issues, recent surgeries, etc.)

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

Are you currently taking Vitamins, Herbs or Supplements?  Yes  No

<u>Vitamin, Herb or Supplement Name</u>	<u>Reason</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**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: \_\_\_\_\_

**Eating Habits** (please be as honest as possible so that we may better help you)

**Breakfast**

Do you have **breakfast** every morning?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

Do you have a **snack** before lunch?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

**Lunch**

Do you have **lunch** every day?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

Do you have a **snack** before dinner?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

**Dinner**

Do you have **dinner** every day?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

Do you eat a **snack** at night?  Yes  Sometimes  Never

Approximate Time: \_\_\_\_\_

Examples: \_\_\_\_\_  
\_\_\_\_\_

**Other**

Do you prefer:  Sweet foods  Salty foods  Fatty foods

Are you a vegetarian?  Yes  No

How much pop do you consume per day? \_\_\_\_\_

How many glasses of water do you drink per day? \_\_\_\_\_ Glasses

How many cups of coffee do you drink per day? \_\_\_\_\_ Caffeinated Cups \_\_\_\_\_ Decaffeinated Cups

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, how much, and how often? \_\_\_\_\_  
\_\_\_\_\_

**What will be the hardest thing for you to give up? If anything?**

\_\_\_\_\_  
\_\_\_\_\_

**Are you an emotional eater?**  Yes  No

**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 seconds 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

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

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:

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