



What is the date of the information session you attended? _____

Which Transformations location do you plan on attending? Savoy Monticello

Are you a Christie registered patient? Yes No

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)

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? _____

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? _____

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 do 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 second's 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: _____

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. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____
- 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!”