

What is the date of the information session you attended?

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

Are you a Christie registered patient? □ Yes □ No

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

 \Box 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.

<u>General</u>

| 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 Tr | ansformations? (Please che | ck all that apply) | | |
| Referral from my physic | cian | Brochure Radio ad | | |
| TVWeb site/Google | e Referred from anothe | er dieter | | |
| Other | | | | |
| Please Answer Weight: | lbs. Weight 1 yea | ar 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 import Transformations medically supervised weight los | | |
|---|--|--|
| Do you exercise? | | |
| | | |
| If yes, what kind? | | |
| How Often and at what intensity? | | |
| Have you been on a diet before? Yes N | lo | |
| If yes, please specify which diet and why you think it cooking involved, etc.): | | |
| Family Life: What is your marital status? M S D W Do y Number of children: Ages: | | |
| Medical Conditions | | |
| Diabetes: Do you have diabetes? Yes No (if No, skip) If so, are you under the care of a physician? Y If so, which type? Type I – Insulin dependent (insulin injectio) Type II – Non-insulin dependent (diabetic) Type II – Insulin dependent (diabetic) Type II – Insulin dependent (diabetic) Is your blood sugar level monitored? Yes If so, by whom? | ′es □ No ons only) pills) and insulin) o | |
| Do you tend to have low blood sugar ? U Yes | s 🗆 No | |
| Cardiovascular Health: Have you had any cardiac problems? If so, please specify (heart attack, stroke, heart failure | ☐ Yes e, stents, etc): | □ No |
| 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 |
| <i>Hypertension</i> : Do you have high blood pressure? If so, do you have your blood pressure checked? If so, are you under the care of a physician? | 🗆 Yes | □ No (if no, skip to next section) □ No □ No |

| <u>Kidney Health:</u> | |
|---|--|
| 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? | \Box 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 |
| Colon Health | |
| Do you have: None of these (if none, skip to next set) | ection) \Box Irritable Bowel \Box Colitis |
| | □ Crohn's disease □ Constipation |
| | \Box Yes \Box No |
| | |
| Stomach/Digestive Health: | |
| Do you have: None of these (if none, skip to next se | ection) \Box Acid Reflux \Box 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: \Box N | None (skip to next section) |
| | |
| □ Irregular periods □ Menopause | Fibrocystic Breasts |
| □ Painful Periods □ Hysterectomy | Heavy periods |
| □ Amenorrhea □ Uterine fibroma | □ Cancer (uterus, breast) |
| | |
| | |
| • | |
| | |
| Please indicate the date of your last menstrual cycle: | |
| Thyroid Function | |
| | \Box Yes \Box No (if no skip to pext section) |
| | |
| in so, are you under the care of a physician: | |
| Emotional Evaluation | |
| Do any of the following apply to you? \Box None of these | e (if none, skip to next section) |
| □ Depression □ Anxiety | □ Panic Attacks |
| □ Bulimia (or history of) □ Anorexia (or history | tory of) |
| If so, are you under the care of a physician? | □ Yes □ No |
| Relevant Notes: | |
| | |
| Lung/Breathing Problems | |
| | |
| 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: | _ |
| Flease indicate the date of your last mensitual cycle. | |
| Thuroid Eurotion | |
| Thyroid Function | |
| Do you have thyroid problems? | \Box Yes \Box No (if no, skip to next section) |
| If so, are you under the care of a physician? | |
| | |
| Emotional Evoluction | |
| Emotional Evaluation | |
| | (if none align to next contian) |
| Do any of the following apply to you? \Box None of these | e (if none, skip to next section) |
| | |
| □ Depression □ Anxiety | Panic Attacks |
| | |
| | |
| Bulimia (or history of) Anorovia (or history) | tory of) |
| □ Bulimia (or history of) □ Anorexia (or history | tory of) |
| | |
| | |
| If so, are you under the care of a physician? | 🗆 Yes 🗆 No |
| If so, are you under the care of a physician? | 🗆 Yes 🗆 No |
| It 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? | ne 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: | \Box None of these (if none, skip to next section) |
| □ Neck pain □ Arm pain □ Mi | d back or low back pain \Box Hip pain |
| □ Thigh or leg pain □ Elbow, wrist, knee or a | nkle 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? | Are you breastfeeding? □ Yes □ No |
| Do you get cold easily? \Box Yes \Box No | Do you have cold hands/feet? |
| Have you been diagnosed with sleep apnea? | - |
| | |
| Do you have other health problems? U Yes If so, please specify: (Cholesterol Issues, recent sur | |
| If so, are you under the care of a physician? | □ Yes □ No |
| Are you currently taking Vitamins, Herbs or Supplem <u>Vitamin, Herb or Supplement Name</u> 1 2. | nents? □ Yes □ No <u>Reason</u> |
| | |
| 3 | |
| Allergies Do you have any food allergies? | Yes 🗆 No |
| Do you have any medication allergies? | Yes 🗆 No |
| Eating Habits (please be as honest as possible so | that we may better help you) |
| Breakfast | |
| | Yes 🗆 Sometimes 🗆 Never |
| LAINPIGS | |

| 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 | |
| Dinner Do you have dinner every day? Approximate Time: Examples: | □ Yes | □ Sometimes | □ Never |
| Do you eat a snack at night? Approximate Time: Examples: | □ Yes | □ Sometimes | □ Never |
| 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? 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 <u>alcohol</u> ? 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? Ves 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------2-----3------5-----6-----7-----8-----9------10 Never occurs Constant

<u>Appetite</u>

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------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? \Box Yes \Box 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:

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

Physician Name

Address

Phone # and or Fax #

Medications (if you are unsure please check your Rx bottles)

| 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 |
| | | | | | |
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*or mEq or dosage your doctor prescribes.

Please Check "No" if it does not apply to you.

| | For Office Use Only | |
|------------|---------------------|--|
| Da | ate: | |
| Total | | |
| Trigly. | | |
| HDL | | |
| LDL | | |
| Glucose | | |
| A1C | | |
| Sodium | | |
| Potassium | | |
| BUN | | |
| Creatinine | | |