Health Profile

Our 30/10 program is intended to help participants with their personal weight loss efforts. We are not a medical facility, and our staff cannot give you medical or psychological advice. You should consult with a physician before beginning any weight-loss program, but especially if you have any health conditions or are taking medication.

General: Date:_____

Last Name: _____ *First Name:* _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Best Contact Phone Number: _____ *Email:* _____

Date of Birth: _____Age: _____Profession: _____

Whom may we thank for referring you: _____

Weight: _____ lbs Height: ____ft_____inches

How much do you want to weigh? _____

Do you exercise? ☐ Yes ☐ No If yes, what kind? _____

How often? _____

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.): _____

On a Scale of 1-10, indicate what level of importance you give to losing weight (10 being the most important)? #____

On a Scale of 1-10, what is the level of stress in your life (10=maximum stress)? #_____

Do you sleep well and wake up rested? Y / N

Have you been diagnosed with sleep apnea? Y / N

Do you have pain anywhere in your body? (If yes, please list problem area of pain): _____

_____

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Family Life:

Marital Status: M S D W
Number of children: _____ Ages: _____

Medical Information:

Please list any physicians you see and their specialty: _____

_____

_____

1) Diabetes:

Do you have Diabetes *(if no, skip to next section)* Yes ☐ No ☐

If so, are you under the care of a physician? ☐ Yes ☐ No
What type of Diabetes do you have:

a. Type I-insulin dependent (insulin injections only) ☐ Yes N

b. Type II-non-insulin dependent (diabetic pills) Yes ☐

c. Type II-insulin dependent (diabetic pills & insulin) ☐ Yes C

Is your blood sugar level monitored? ☐ Yes ☐ No
If so, by whom? ☐ Myself ☐ Physician ☐ Other (please specify): _____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

2) Cardiovascular Function (Heart and Vascular Conditions):

Are you currently taking medication for high blood pressure ☐ Yes ☐ No
Has your doctor restricted your salt intake? ☐ Yes ☐ No
Are you taking cholesterol medication? ☐ Yes ☐ No

Have you had any of the following cardiovascular conditions? ☐ NONE

a. ☐ Blood Clot N-L
b. ☐ Pulmonary Embolism N-L
c. ☐ Stroke or TIA N-L
d. ☐ Coronary Artery Disease N-L
e. ☐ Heart Valve Problem N-L
f. ☐ Heart Valve Replacement N-L
(porcine/mechanical)
g. ☐ Arrhythmia/ A-fib L
h. Heart Attack
i. ☐ In the last 6 months? N
ii. ☐ More than 6 months ago? L
i. Congestive Heart Failure
i. ☐ History of Congestive Heart Failure L
ii. ☐ Current Congestive Heart Failure N
j. Do you have a pacemaker? ☐ Yes C-L

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2) Cardiovascular Function (Heart and Vascular Conditions) (Con't):

Have you ever had ANY type of heart surgery? ☐ Yes ☐ No
If so, which type? _____
Other conditions: _____
If you have answered yes to any of these conditions, please give dates of occurrence: _____
_____

3) Kidney Function:

a. Have you been diagnosed with kidney disease? ☐Yes C-L ☐ No
b. Have you ever had kidney transplant? ☐Yes L ☐ No
Are you taking any medication for this condition? ☐Yes ☐ No
Please list and medication you are taking for these conditions: _____
_____

c. Have you ever had Kidney Stones? ☐Yes C ☐ No
d. Have you ever had Gout? ☐Yes C ☐ No

4) Liver Function:

a. Do you have liver problems? ☐Yes C-L ☐ No
If so, please specify: _____

5) Colon Function:

Do you have: ☐ NONE

a. ☐ Irritable Bowel Syndrome
b. ☐ Diverticulitis
c. ☐ Constipation
d. ☐ Ulcerative Colitis C
e. ☐ Crohn's Disease C
f. ☐ Diarrhea

If yes to any of these conditions, please give dates of events: _____
_____

6) Stomach/Digestive Function:

Do you have any of the following conditions? ☐ NONE

a. ☐ Acid Reflux
b. ☐ Heartburn
c. ☐ Gastric Ulcer C-L
d. ☐ History of Bariatric Surgery C-L
If so, what type of Bariatric Surgery:
_____

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7) Ovarian/ Breast Function:

Check off the conditions that apply to you currently: ☐ NONE

a. ☐ Irregular Periods
b. ☐ Fibrocystic Breasts
c. ☐ Hysterectomy
d. ☐ Amenorrhea
e. ☐ Menopause
f. ☐ Painful Periods
g. ☐ Heavy Periods
h. ☐ Uterine Fibroma
i. ☐ Cancer (Uterus, Breast) L
Date: _____

1. Are you pregnant? ☐ Yes N ☐ No
2. Are you breastfeeding? ☐ Yes N ☐ No

8) Endocrine/Glandular Function:

☐ NONE

a. Do you have thyroid problems? ☐ Yes ☐ No
b. Do you have parathyroid problems? ☐ Yes ☐ No
c. Do you have adrenal gland problems? ☐ Yes ☐ No

9) Neurological/Emotional Evaluation:

NON☐

Do any of the following apply to you?

a. ☐ Panic Attacks
b. ☐ Anxiety
c. ☐ Depression
d. ☐ Schizophrenia
e. ☐ Anorexia (history of) C
f. ☐ Bulimia (history of) C
g. ☐ Bipolar Disorder N-L
h. ☐ Epilepsy C-L
i. ☐ Alzheimer's Disease N
j. ☐ Parkinson's Disease N

Please list any medications you are taking for these conditions: _____
_____

10) Inflammatory Conditions:

NONE☐

Do any of the following apply to you?

a. ☐ Migraines
b. ☐ Psoriasis
c. ☐ Fibromyalgia
d. ☐ Rheumatoid Arthritis
e. ☐ Osteoarthritis
f. ☐ Lupus
g. ☐ Chronic Fatigue Syndrome
h. ☐ Multiple Sclerosis
i. ☐ Other Autoimmune/Inflammatory Condition: _____

11) Cancer:

☐ NONE

a. Do you have active cancer? ☐Yes N-L ☐No
If so what type and where is it located? _____
b. Has your cancer been in remission for less than 5 years? ☐Yes L ☐No
If so what type and where is it located? _____
c. Has your cancer been in remission for more than 5 years? ☐Yes ☐No
If so, please specify & indicate how long: _____

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12) General:

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Do you take any other medications? ☐ Yes ☐ No

If so, please specify: _____

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

	Vitamin, Herb or Supplement Name	Reason
1.		
2.		
3.		
4.		

Are you a vegetarian? ☐ Yes C ☐ No

Do you adhere to a strict vegan lifestyle? Yes ☐ No ☐

13) Allergies: ☐ NONE

Are you gluten intolerant? ☐ Yes C ☐ No

Do you have Celiac's Disease? ☐ Yes C ☐ No

Are you allergic to Peanuts ☐ Yes C ☐ No

Soy ☐ Yes C ☐ No

Dairy ☐ Yes C ☐ No

Do you have any *Food* allergies? ☐ Yes ☐ No

If so, please list: _____

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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 of foods: _____

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

Approx. Time: _____

Examples of foods: _____

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

Approx. Time: _____

Examples of foods: _____

Do you have a **snack** between lunch and dinner? ☐Yes ☐Sometimes ☐Never

Approx. Time: _____

Examples of foods: _____

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

Approx. Time: _____

Examples of foods: _____

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

Approx. Time: _____

Examples of foods: _____

Other:
Do you prefer: ☐ Sweet Foods ☐ Salty Foods ☐Fatty Foods
How many glasses of water do you drink per day? _____ glasses
How many 8 oz cups of coffee do you drink per day? _____ cups
Do you drink soda? ☐ Diet ☐Reg ☐None
Do you drink alcohol? ☐Y ☐N If so, what and how often: _____

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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

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Signature: _____ Date: _____

The signatory client hereby recognizes the accuracy of the information provided herein.

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Informed Consent for 30/10 Weight Loss Program

The 30/10 WLFL solution is designed to help you to lose weight. You will be eliminating junk foods and sugars in your current diet and replacing them with foods and products your body can more effectively utilize. You will be encouraged to prepare a dinner meal for yourself consisting of an animal protein of your choice (beef, chicken, pork, fish…) and two or more cups of vegetables for both dinner and lunch. We will be providing you with food products to support a healthy protein intake for your breakfast, lunch and mid-day snack.

Your payment for 30/10 services is based upon the number of weeks on the program you sign up for, not upon the number of pounds you have to lose.

Weight loss requires a healthy diet and fitness program. There is no guarantee this program will work for you because your success depends upon a variety of factors, including your commitment to the program. If you deviate from the program you may not realize your desired results.

The 30/10 Weight Loss Solution is about working toward weight loss for life, not just a short term weight loss goal.

You are encouraged to call the office any time during office hours with any questions or support you may need. We are here to help you and we want you to succeed.

The 30/10 program is intended to help participants with their personal weight loss efforts. We are not a medical clinic and our staff cannot give you medical advice or diagnosis. Nothing in our program should be construed as medical or psychological advice or diagnosis. The information provided by 30/10 is not a substitute for physician consultation, evaluation or treatment.

As you lose the weight you should contact your family doctor to check on your health. You should never take yourself off any medications; you must always consult with your family doctor regarding reducing or stopping medications.

I have been informed as to the 30/10 protocol and I am prepared to engage the process.

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NAME_____ DATE_____

If under the age of 18, client will need parental consent.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature:_____

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