



Gerber Family Chiropractic
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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: _____ Middle Initial: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email Address: _____ Date of Birth: _____ Age: _____
 Profession: _____ Whom May We Thank for Your Referral: _____
 Weight Now: ____ lbs. Weight 1 year ago: ____ lbs. Minimum Adult Weight: ____ lbs at age ____
 Maximum Weight: ____ lbs. at age ____ Current Height: _____

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 TO 10, INDICATE WHAT LEVEL OF IMPORTANCE YOU GIVE TO LOSING WEIGHT VIA IDEAL PROTEIN'S MEDICALLY SUPERVISED WEIGHT LOSS METHOD (10 being the most important): _____

FAMILY LIFE:

What is your marital status? M S D W Do you have children? ___ Yes ___ No
 Number of Children: ____ Ages: _____

MEDICAL INFORMATION:

Please list any physicians you see and their specialty:



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DIABETES:

Do you have diabetes? Yes 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): _____

Are you taking any medication? Yes No

If so, please list: _____

Do you tend to be hypoglycemic? Yes No

CARDIOVASCULAR HEALTH:

Have you had a cardiovascular event? Yes No (if no, skip to next question)

If so, please specify: _____

How long ago: _____

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

Are you taking any medication? Yes No

If so, please list: _____

Do you have a history of arrhythmia? Yes No

HYPERTENSION:

Do you have high blood pressure? Yes No (if no, skip to next question)

If so, do you have your blood pressure checked? Yes No

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

Are you taking any medication? Yes No

If so, please list: _____

KIDNEY HEALTH:

Have you been diagnosed with kidney disease? Yes No (if no, skip to next question)

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

Are you taking any medication? Yes No

If so, please list: _____

Have you ever had Gout? Yes No



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LIVER HEALTH:

Do you have liver problems? Yes No (if no, skip to next question)

If so, please specify: _____

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

Are you taking medication? Yes No

If so, please list: _____

COLON HEALTH:

Do you have: Irritable Bowel Colitis Diarrhea
 Constipation Crohn's Disease Diverticulitis

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

Are you taking medication? Yes No

If so, please list: _____

STOMACH/DIGESTIVE HEALTH:

Do you have: Acid Reflux GastricUlcer Heartburn Celiac Disease

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

Are you taking medication? Yes No

If so, please list: _____

OVARIAN/BREAST HEALTH:

Check the situations that apply to you currently:

Irregular Periods Menopause Fibrocystic Breast Painful Periods
 Hysterectomy Heavy Periods Amenorrhea Uterine Fibroma
 Cancer (Uterus, Breast)

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

Are you taking medication? Yes No

If so, please list: _____

THYROID FUNCTION:

Do you have thyroid problems? Yes No (if no, skip to the next question)

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

Are you taking medication? Yes No

If so, please list: _____



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EMOTIONAL EVALUATION:

Do any of the following apply to you? (if no, skip to the next question)

- Depression Anxiety Panic Attacks
 Bulimia (or history of) Anorexia (or history of)

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

Are you taking medication? Yes No

If so, please list: _____

INFLAMMATORY CONDITIONS:

Do any of the following apply to you? (if no, skip to the next question)

- Migraines Fibromyalgia Rheumatoid Arthritis
 Lupus Osteoarthritis Chronic Fatigue Syndrome
 Psoriasis

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

Are you taking medication? Yes No

If so, please list: _____

GENERAL:

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

Are you taking medication? Yes No

If so, please list: _____

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 feet/hands: Yes No

Do you have health problems: Yes No

If so, please specify: _____

If so, are you under the care of a physician: Yes No

Are you taking any medication: Yes No

If so, please list: _____

Are you current taking Vitamins, Herbs or Supplements: Yes No

VITAMIN/HERB/SUPPLEMENT

REASON

1. _____
2. _____
3. _____
4. _____
5. _____



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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 have 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 many glasses of **water** do you drink per day: _____ glasses

How many cups of **coffee** do you drink per day: _____ 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 kind, how much and how often: _____



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CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger

Score each item on a 0 to 10 number scale. Each feeling represents a different part of the brain and different neurotransmitters

Compulsions/Cravings: Feeling or urge to eat when not hungry, often associated with other emotions. 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 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 of any or all of your prescription medications:
 ___ Yes ___ No

You must take vitamins and minerals while you are on the Ideal Protein Weight Loss Method. If you stop taking them, you may experience undesirable side effects. ___ (Client's Initials)

If you have health problems not indicated on this health profile, please consult with your physician prior to starting this program.

Client Signature: _____ Date: _____

If Client Is Under 18 years of age, a parent's signature is required.

Parent Signature: _____ Date: _____

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.