Weight Loss Profile

Weight Loss 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: _____

Age: _____ Profession: _____ Phone Number: (_____) _____

Email: _____

How did you hear about us? _____

Weight: _____ Goal Weight: _____ Desired Completion Date: _____

Minimum Adult Weight: _____ at age: _____

Maximum Adult Weight: _____ at age: _____

Do you exercise? ☐ Yes ☐ No

If yes, what kind?_____

How Often? _____

In the last 6 months, have you had any stiffness, pain, or arthritic problems? ☐ Yes ☐ No

Where? *(Circle all that apply)* Neck...Mid back...Low back...Hips…Knees...Foot/Ankle...Shoulders...Arm...Hand/Wrist

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: _____

_____

Family Life

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

Number of children: _____ Ages: _____

Medical Information

Please list any physicians you see and their specialty:

_____

_____

_____

_____

Diabetes

Do you have diabetes? ☐ Yes ☐ No *(If no, skip to Cardiovascular Function)*

Are you under the care of a physician? ☐ Yes ☐ No

Which type of diabetes do you have?

☐ Type I – Insulin dependent (insulin injections only)

☐ Type II – Non-insulin dependent (diabetic pills)

☐ Type II – Insulin dependent (diabetic pills and insulin injections)

Is your blood sugar level monitored? ☐ Yes ☐ No

If so, by whom? ☐ Myself ☐ Physician ☐ Other (please specify): _____

Are you taking any medication? ☐ Yes ☐ No

If so, please list:_____

_____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

Cardiovascular Function

Have you had a cardiovascular event? ☐ Yes ☐ No *(If no, skip to Hypertension)*

Please specify: _____

When did it occur? _____

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

Have you been diagnosed with Congestive Heart Failure (CHF)? ☐ Yes ☐ No

Hypertension

Do you have high blood pressure? ☐ Yes ☐ No *(If no, skip to Kidney Function)*

Do you have your blood pressure checked regularly? ☐ Yes ☐ No

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please list: _____

Kidney Function

Have you been diagnosed with kidney disease? ☐ Yes ☐ No

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 kidney stones? ☐ Yes ☐ No

Have you ever had gout? ☐ Yes ☐ No

Colon Function

Do you have any of the following? *(Select all that apply):*

☐ Irritable Bowel ☐ Colitis ☐ Diarrhea ☐ Diverticulosis

☐ Crohn's Disease ☐ Constipation ☐ None *(If none, skip to Stomach/Digestive)*

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please list: _____

Stomach/Digestive Function

Do you have any of the following? *(Select all that apply):*

☐ Acid Reflux ☐ Gastric Ulcer ☐ Heartburn ☐ Celiac Disease

☐ None *(if none, skip to Ovarian/Breast Function)*

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please list: _____

Ovarian/Breast Function

Check all that currently apply to you:

☐ Irregular Periods ☐ Menopause ☐ Fibrocystic Breasts ☐ Painful Periods

☐ Hysterectomy ☐ Heavy Periods ☐ Amenorrhea ☐ Uterine Fibroma

☐ Cancer ☐ None *(If none, skip to Thyroid Function)*

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If yes, please list: _____

Please indicate the date of your last menstrual cycle: _____

Thyroid Function

Do you have a thyroid problem? ☐ Yes ☐ No *(If no, skip to Emotional Evaluation)*

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please list: _____

Emotional Evaluation

Do any of the following apply to you? *(Select all that apply):*

☐ Depression ☐ Anxiety ☐ Panic Attacks ☐ Bulimia *(or history of)*

☐ Anorexia *(or history of)* ☐ None *(If none, skip to Inflammatory Conditions)*

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If so, please list: _____

Inflammatory Conditions

Do any of the following apply to you? *(Select all that apply):*

☐ Migraines ☐ Fibromyalgia ☐ Rheumatoid Arthritis ☐ Osteoarthritis

☐ Lupus ☐ Chronic Fatigue Syndrome ☐ Psoriasis ☐ None *(if none, skip to General)*

☐ Other autoimmune or inflammatory condition (Please specify):_____

_____

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If yes, please list: _____

General

Do you have Parkinson's disease? ☐ Yes ☐ No

Do you have cancer? ☐ Yes ☐ No

Are you in cancer remission? ☐ Yes ☐ No

If so, for how long? _____

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any 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 hands/feet? ☐ Yes ☐ No

Do you have other health problems? ☐ Yes ☐ No

If so, please specify:_____

_____

_____

_____

Are you under the care of a physician? ☐ Yes ☐ No

Are you taking any other medications not listed above? ☐ Yes ☐ No

If so, please list:_____

_____

_____

_____

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: _____

Are you currently taking medications, vitamins, herbs, or supplements? ☐ Yes ☐ No

If so, please list and give the reason for taking it: _____

_____

Eating Habits

Please be as honest as possible so that we may better help you.

Breakfast

Do you have breakfast every morning? ☐ Always ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before lunch? ☐ Always ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Lunch

Do you have lunch every day? ☐ Always ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before dinner? ☐ Always ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Dinner

Do you have dinner every day? ☐ Always ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack at night? ☐ Always ☐ 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 in a day? _____

How many cups of COFFEE do you drink in a day? _____

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? _____

CASH Scale (Compulsions/Cravings Appetite Satiety Hunger)

Score each item on a scale of 0-10. 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 and there is no food in sight yet 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. Imagine this scenario: you recently ate and feel full. You walk into a room and there is food everywhere. It looks and smells good and 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 Eat One Plate Have Seconds Have Thirds

Hunger

That feeling of a pain or ache in your stomach when it is really empty. This is a true pain or discomfort.

0 1 2 3 4 5 6 7 8 9 10

Never Hungry Constant Hunger

blueprint nutrition

Consultation Questions

1. What's your main goal: weight loss or overall health? _____

2. What price range are you looking to stay in? _____

3. Have you been shopping around for any other weight loss programs? _____

4. On a scale of 1 to 10, what is your willingness to:

   Learn?

   Change?

70% or above = GREEN
69% - 50% = YELLOW
49% or below = RED

5. What are you going to do when you reach your goal? _____

6. Do you feel your health and/or weight keeps you from doing anything?_____

7. What's the one thing you think is going to be hardest for you? _____

   _____

8. Are you someone who can be successful on your own or do you need accountability? _____

9. Who do you listen to when it comes to weight loss and overall health? _____

   _____

10. How long have you been on your weight loss journey? _____

11. What do you think was the cause of your weight gain? _____

12. What matters more, inches or weight? _____

Weight Loss Profile

Home Testing

IRIS CONTRACTION TEST

The iris contraction test is a simple, at-home tool that measures your body's stamina in response to light stimulation. If your stamina is decreased, this test may indicate that your adrenals are having difficulty supporting you through stressful events. Follow the instructions below to test your adrenals.

1. In a dark room, stand in front of a mirror for about a minute to allow your eyes to adjust to the light.

2. Shine a flashlight across one eye (not directly into it) from the side of your head (keep the light about six inches away).

3. Keep the light shining across one eye and watch in the mirror with the other. You should see your pupil c contract immediately as the light hits your eye.

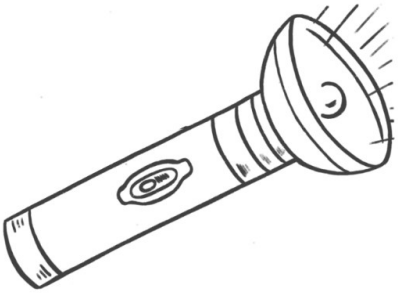
   This occurs because the iris, a tiny circular muscle composed of small muscle fibers, contracts and dilates the pupil in response to light. Just like any muscle, after it has been exercised beyond normal capacity, it likes to rest.

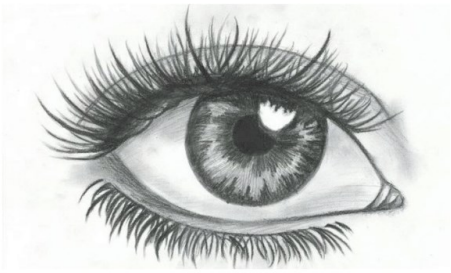
4. Time how long the dilation lasts with the seconds hand on the watch or your phone and record it along with the date.

   The pupil normally remains contracted in the increased light. But if you have some form of adrenal fatigue, the pupil will not be able to hold its contraction and will dilate despite the light shining on it. This dilation will take place within 2 minutes and will last for about 30-45 seconds before it recovers and contracts again.

5. After you do this once, let the eye rest. If you have any difficulty doing this on yourself, do it with a friend. Have a friend shine the light across your eye while both of you watch the pupil size.

6. Retest monthly. If your eye indicates you are suffering from adrenal fatigue, this also serves as an indicator of recovery. As you recover from adrenal fatigue, the iris will hold its contraction and the pupil will remain small for longer."





Adrenal Fatigue Test

Check all the boxes that apply to you.
Add up the total and place in the box below.

- ☐ I am frequently tired.
- ☐ I feel tired even after 8 to 10 hours of sleep.
- ☐ I am chronically stressed.
- ☐ It is difficult for me to handle stress.
- ☐ I am a night-shift worker.
- ☐ I work long hours.
- ☐ I have little relaxation time during my days.
- ☐ I get headaches frequently.
- ☐ I don't exercise consistently.
- ☐ I am or have been an endurance athlete (or participate in CrossFit).
- ☐ I have erratic sleep patterns.
- ☐ I wake up in the middle of the night.
- ☐ I crave salt.
- ☐ I have high sugar intake.
- ☐ I have difficulty concentrating.
- ☐ I carry weight in my midsection (an apple-shape body).
- ☐ I have low blood sugar issues (hypoglycemia).
- ☐ I have irregular periods.
- ☐ I have a low libido.
- ☐ I have PMS or perimenopausal/menopausal symptoms.
- ☐ I get sick frequently.
- ☐ I have low blood pressure.
- ☐ I have muscle fatigue or weakness.
- ☐ I rely on caffeine for energy (coffee, energy shots, etc.).

Total: ☐

CANDIDA SPITTLE TEST

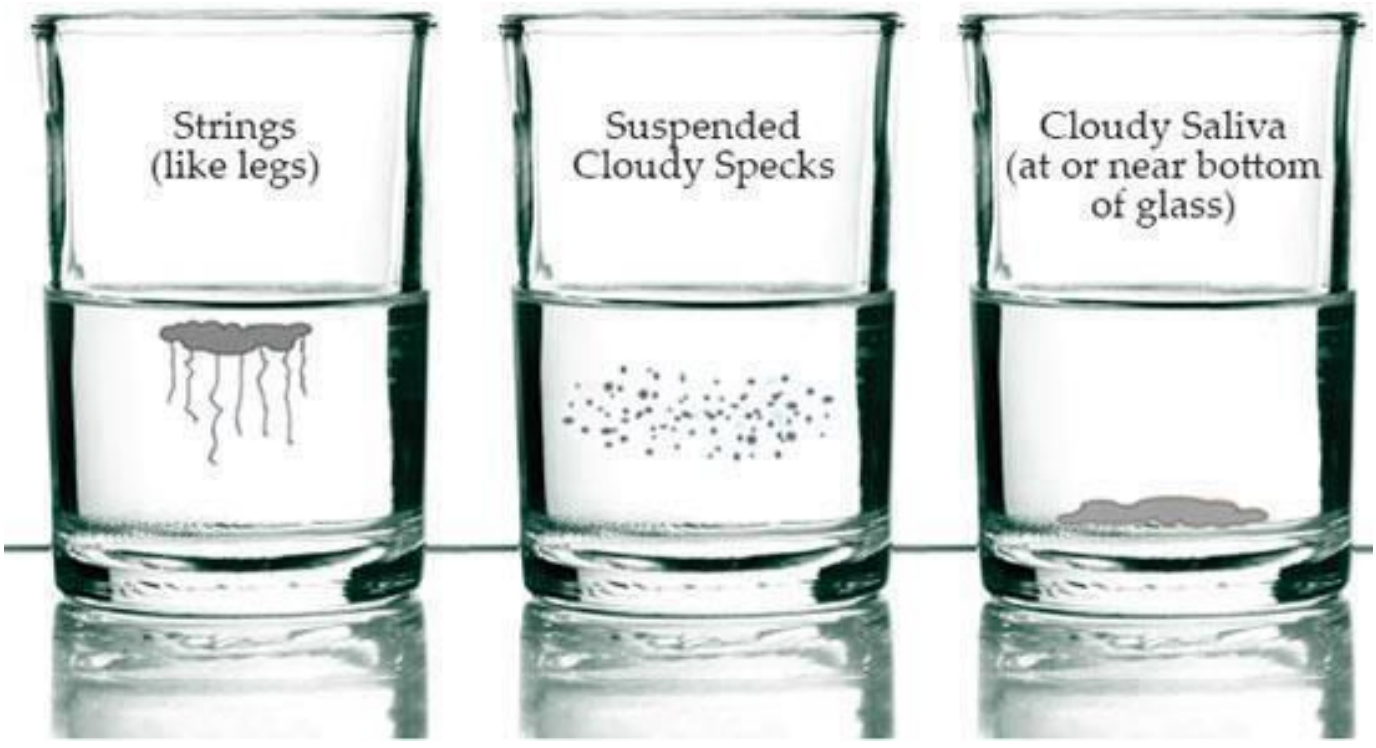
This simple, at home test will help shine some light on your current candida levels. Below are the instructions to complete this test.

1. Take a clear glass of tap water and place it on your bedside table before you go to bed.

2. The next morning, before you do anything, gently spit into the glass.

3. Check in to see the progress of your saliva every 15 minutes for one hour.

4. If your saliva does any variation of the three pictures below, that is a sign of candida overgrowth. If it stays grouped at the top or disperses, that is a sign of little to no candida overgrowth.



CANDIDA QUESTIONNAIRE

Add up the points for the answer to each question below. Once you have your total, read the key below to better understand your current candida overgrowth situation.

QUESTIONS	YES	NO
1. Have you taken repeated or prolonged courses of antibacterial drugs?	4	0
2. Have you been bothered by recurrent vagina, prostate or urinary infections?	3	0
3. Do you feel "sick all over," yet the cause hasn't been found?	2	0
4. Are you bothered by hormone disturbances? *(including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature, or fatigue)*	2	0
5. Are you unusually sensitive to tobacco smoke, perfumes, and other chemical odors?	2	0
6. Are you bothered by memory or concentration problems?	2	0
7. Have you taken prolonged courses of prednisone or other steroids?	1	0
8. Have you taken birth control for more than 3 years?	1	0
9. Do you suffer with constipation, diarrhea, bloating or abdominal pain?	1	0
10. Does your skin itch, tingle or burn, is it unusually dry; or are you bothered by rashes?	1	0
11. When you wake up, do you have a white coating on your tongue?	1	0
TOTAL		

WOMEN

A score of 10 or greater indicates that your health problems may be connected to a Candida overgrowth.

A score of 13 or higher suggests that your symptoms are very likely to be related to Candida.

MEN

A score of 8 or greater indicates that your health problems may be connected to a Candida overgrowth.

THYROID UNDERARM TEST

This simple, at home test will help you get an idea about your current thyroid function. Below are the instructions to complete this test.

1. Before you go to bed, place a digital or basal thermometer on your bedside table.

2. The next morning, before getting out of bed, take your temperature for 10 minutes under both arms.

3. Do this up to 3 days and record your results each day.

4. If your temperature is below 97.4 degrees, that is the sign of a sluggish thyroid.

You can record your results here:

Day 1: _____ Left
_____ Right

Day 2:_____ Left
_____ Right

Day 3:_____ Left
_____ Right

WHAT TO EXPECT ON MY NEXT VISIT

1. Go over your home test results.
2. Discuss what program is best suited for you, if any.
3. Answer any questions about the program you may have.
4. Review cost of the program.
5. Receive your Blueprint resources and watch short *(7 min.)* introductory video.