CHIRO-MED

Excellence in Chiropractic Medicine

3200 WEST MAIN STREET
BELLEVILLE, IL 62226
618-235-3200 • Fax 618-235-3282
E-mail: chiromed1@aol.com

1480 NORTH GREEN MOUNT RD.
O'FALLON, IL 62269
618-622-2222 • Fax 618-624-8357
E-mail: chiromedofallon@sbcglobal.net

www.chiromedltd.com

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: _____

Address:_____ Apt/Unit: # _____

City:_____ State:_____ Zip: _____

Phone:_____ Cell:_____ E-mail:_____

Date of Birth:_____ Age:_____ Profession: _____

Whom may we thank for referring you?_____

Weight:_____lbs. Weight 1 year ago:_____ lbs. Min. Adult Weight:_____lbs at age _____

Maximum Weight:_____lbs. at age_____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, how committed are you to losing fat on this program? (10 being the highest level of commitment): _____

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:

_____

_____

_____

_____

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:_____

List all medications for allergies on back sheet.

Cardiovascular Function:

Have you had a cardiovascular event? ❑ Yes ❑ No (if no, check box and skip to next section)

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

List all medications for cardiovascular function on back sheet.

Do you have a history of arrhythmia ❑ Yes ❑ No

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

Colon Function:

Do you have: ❑ Irritable Bowel ❑ Colitis ❑ Diarrhea ❑ Diverticulosis?
❑ Crohn's disease ❑ Constipation

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

Are you taking any medication? ❑ Yes ❑ No

List all medications for colon function on back sheet.

Diabetes:

Do you have diabetes? ❑ Yes ❑ No (if no, check box and 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

List all medications for diabetes on back sheet.

Do you tend to be hypoglycemic? ❑ Yes ❑ No

Emotional Evaluation:

Do any of the following apply to you? (if no, 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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for emotional conditions on back sheet.

General:

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

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 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: _____

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

Are you taking any medications for any of the above? ❑ Yes ❑ No

List all medications for the above on back sheet.

Hypertension:

Do you have high blood pressure? ❑ Yes ❑ No (if no, check box and 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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for hypertension on back sheet.

Inflammatory Conditions:

Do any of the following apply to you? (if no, 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

If so, are you taking any medication? ❑ Yes ❑ No

List all medications for inflammatory conditions on back sheet.

Kidney Function:

Have you been diagnosed with kidney disease? ❑ Yes ❑ No (if no, check box and skip to next section)
If so, are you under the care of a physician? ❑ Yes ❑ No
Are you taking any medication? ❑ Yes ❑ No
List all medications for kidney function on back sheet.
Have you ever had Kidney Stones? ❑ Yes ❑ No
Have you ever had Gout? ❑ Yes ❑ No

Liver Function:

Do you have liver problems? ❑ Yes ❑ No (if no, check box and skip to next section)
If so, please specify: _____
If so, are you under the care of a physician? ❑ Yes ❑ No
Are you taking any medication? ❑ Yes ❑ No
List all medications for liver function on back sheet.
If so, are you under the care of a physician? ❑ Yes ❑ No
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for liver function on back sheet.

Muscular/Skeletal Conditions:

In which areas do you have aches or pains:
❑ Neck ❑ Back ❑ Knees ❑ Other _____
How often do you take Ibuprofen or other pain reducing medications for the above? _____
List all medications for muscular/skeletal conditions on back sheet.
Do you have arthritis? If so, where? _____
Are you under the care of a physician for your aches and pains? ❑ Yes ❑ No
Do you feel your weight has damaged or "worn down" any of your joints? ❑ Yes ❑ No

Ovarian/Breast Function:

Check off the situations that apply to you currently:
❑ Irregular Periods ❑ Menopause ❑ Fibrocystic Breasts
❑ Painful Periods ❑ Hysterectomy ❑ Heavy periods
❑ Amenorrhea ❑ Uterine Fibroma ❑ Cancer (uterus, breast)
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for ovarian/breast function on back sheet.
Please indicate the date of your last menstrual cycle: _____

Stomach /Digestive Function:

Do you have: ❑ Acid Reflux ❑ Gastric Ulcer ❑ Heartburn ❑ Celiac Disease?
If so, are you under the care of a physician? ❑ Yes ❑ No
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for stomach/digestive function on back sheet.

Thyroid Function:

Do you have thyroid problems? ❑ Yes ❑ No (if no, check box and skip to next section)
If so, are you under the care of a physician? ❑ Yes ❑ No
If so, are you taking any medication? ❑ Yes ❑ No
List all medications for thyroid function on back sheet.

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

	Vitamin, Herb or Supplement Name	**Reason**
1.		
2.		
3.		
4.		
5.		

Eating Habits: (please be as honest as possible so that we may better help you)

Breakfast

Do you have **breakfast** every morning? ❑ Yes ❑ No ❑ Never
Approximate Time:_____
Examples: _____

Do you have a **snack** before lunch? ❑ Yes ❑ No ❑ Never
Approximate Time:_____
Examples: _____

Lunch

Do you have **lunch** every day? ❑ Yes ❑ No ❑ Never
Approximate Time:_____
Examples: _____

Do you have a **snack** before dinner? ❑ Yes ❑ No ❑ Never
Approximate Time:_____
Examples: _____

Dinner

Do you have **dinner** every day? ❑ Yes ❑ No ❑ Never
Approximate Time:_____
Examples: _____

Do you eat a **snack** at night? ❑ Yes ❑ No ❑ 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 yrs?_____

Do you drink alcohol? ❑ Yes ❑ No

If yes, what, how much, and how often? _____

_____

CASH Scale: Compulsions or **C**ravings/**A**ppetite/**S**atiety/**H**unger

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

You must take vitamins and minerals while you are on the Chiro-Med Weight Loss Program. If you stop taking them, you may experience undesirable side effects._____ (Client's initials)

If you are taking medications, are you interested in getting off of any or all of your prescription medications? ❑ Yes ❑ No

If you have health problems not indicated on this health profile, please consult your physician.

Obesity affects entire families. Do you have any family members who could benefit from this program? ❑ Yes ❑ No

Please list all medications which you take on back side of this page.

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 Chiro-Med Weight Loss Program.

You must talk to Dr. Laux prior to starting this diet if you have a history of any of the following:

- History of a cardio-vascular event: (i.e. heart attack, stroke, aneurysm, by-pass, stent surgery, history of having cardiac arrhythmia including have a pace-maker)
- History of or current active cancer; including skin cancers
- Pregnant female (note from OB/GYN ONLY)
- Breast-feeding female (note from PEDIATRICIAN ONLY)
- Severe Liver Disease
- Severe Kidney Disesase
- Diagnosis or history of Congestive Heart Failure (CHF)
- Patients currently on Lithium therapy
- Patients with a diagnosis of Parkinson's Disease
- Strict Vegan lifestyle

MEDICATIONS

Please list all medications taken for the following:

Allergies: _____

Cardiovascular function: _____

Colon function: _____

Diabetes: _____

Emotional conditions: _____

General medications: _____

Hypertension: _____

Inflammatory conditions: _____

Kidney function: _____

Liver function: _____

Muscular/skeletal conditions: _____

Ovarian/breast function: _____

Stomach/digestive function: _____

Thyroid function: _____

For Office Use Only

First Appointment	Final Appointment
❑ *Photo*	❑ *Photo*
❑ *Weight* _____	❑ *Weight* _____
❑ *BMI* _____	❑ *BMI* _____
Vitals	*Vitals*
❑ *Blood Pressure* _____	❑ *Blood Pressure* _____
❑ *Pulse* _____	❑ *Pulse* _____

"If you follow the program it works. It's the easiest diet I've ever been on."
-Mark Wachtel (lost 227 lbs. in 50 weeks)