CHRISTIE CLINIC transformations
MEDICAL WEIGHT LOSS PROGRAM

What is the date of the information session you attended? _____

Which Transformations location do you plan on attending? Savoy Monticello

Have you had labs (lipid profile & basic metabolic panel) done within 6-12 months? ☐ I don't know

☐ Yes at Christie Clinic ☐ Other _____

By checking the box for Christie, you are giving Christie Clinic's Transformations team permission to access your records.

(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.***

Fax No. is 366-7469

☐ No ***Please order them for me at Christie Clinic.***

When do you want to get started with the diet?_____

Do you prefer a Saturday for your appointment? YES NO

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.

MEDICATION LIST IS MANDATORY! PLEASE ATTACH TO THE BACK FROM PHYSICIAN.

Last Name: _____ First Name:_____

Address: _____ Apt/Unit: # _____

City:_____ State: _____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone: _____

E-mail: _____ Profession: _____ Employer: _____

Date of Birth: _____ Age: _____ What are your goals? _____

_____

On a scale of 1 to 10, indicate what level of importance do you give to losing weight via the Transformations medically supervised weight loss method (10 being the most important):___

If your your ranking is < 10, let us know what you need to do to increase that number?

_____

_____

How did you hear about Transformations? (Please check all that apply)

___ Brochure , which I picked up from _____ ___ Radio ad

___ Facebook __ Transformations Website ___ Referral from my physician, who?_____

___ Referred from another dieter, if so who? _____

__ Other, please specify _____

Please Answer 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 and at what intensity? _____

_____

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.): _____

_____

Family Life:

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

Number of children:_____ Ages: _____

Do you live alone? ☐ Yes ☐ No

If no, does he/she know you are starting this program? ☐ Yes _ ☐ No

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

Do you experience shortness of breath with daily activities? ☐ Yes ☐ No (expand with comments) _____

Do you use a C-PAP machine? ☐ Yes ☐ No

Have you had recent weight loss or weight gain? ☐ Yes ☐ No _____ (please specify)

Diabetes:

Do you have diabetes? ☐ Yes ☐ No (if 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):

Do you tend to have low blood sugar? ☐ Yes ☐ No

Cardiovascular Health:

Have you had any cardiac problems? ☐ Yes ☐ No

If so, please specify (heart attack, stroke, heart failure, stents, etc):

_____

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

Hypertension:

Do you have high blood pressure? ☐ Yes ☐ No (if no, 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

Kidney Health:

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? ☐ Yes ☐ 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 section)☐ Irritable Bowel ☐ Colitis
☐ Diarrhea ☐ Diverticulosis ☐ Crohn's disease ☐ Constipation

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

Stomach/Digestive Health:

Do you have: ☐ None of these (if none, skip to next section) ☐ Acid Reflux ☐ 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: ☐ None (skip to next section)

☐ Irregular periods ☐ Menopause ☐ Fibrocystic Breasts
☐ Painful Periods ☐ Hysterectomy ☐ Heavy periods
☐ Amenorrhea ☐ Uterine fibroma ☐ Cancer (uterus, breast)
☐ 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: _____

Thyroid Function

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

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

Emotional Assessment

Do any of the following apply to you? ☐ None of these (if none, skip to next section)

☐ Depression ☐ Anxiety ☐ Panic Attacks

☐ Bulimia (or history of) ☐ Anorexia (or history of) ☐ Self Harm

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

Relevant Notes: _____

Lung/Breathing Problems

If so please specify:

_____

_____

Do any of the following apply to you? ☐ None 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: ☐ None of these (if none, skip to next section)

☐ Neck pain ☐ Arm pain ☐ Mid back or low back pain ☐Hip pain

☐ Thigh or leg pain ☐ Elbow, wrist, knee or ankle 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? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you get cold easily? ☐ Yes ☐ No Do you have cold hands/feet? ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Do you have other health problems? ☐ Yes ☐ No

If so, please specify: (Cholesterol Issues, recent surgeries, etc..)

_____

_____

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

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

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

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 eat 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 much pop do you consume per day? _____
How many glasses of water do you drink per day? _____ Glasses
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 alcohol? ☐ Yes ☐ No
If yes, what, how much, and how often? _____
_____

What will be the hardest thing for you to give up? (No alcohol, no bread, starch, fruit, dairy)
_____
_____

Are you an emotional eater? ☐ Yes ☐ No

If no, how do you manage stress? _____

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

If you are taking medications, are you interested in getting off any or all of your prescription medications? ☐ Yes ☐ 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, including if you have done the program before please provide some details about your first experience :

_____
_____
_____
_____

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

Physician Name Address Phone # and or Fax #

_____ _____ _____

_____ _____ _____

Medications - please fill out the following chart if you are on less than 2 medications.

If you are on more than two PLEASE ATTACH YOUR MEDICATION LIST. (include medical & psychotropic meds)

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

*or mEq or dosage your doctor prescribes.

Please list 12 reasons why you want to do this program, including the reasons why you want to lose the weight and lead a healthy lifestyle.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Many of us have several reasons why losing weight is important. Keep these 12 things handy and review them periodically or when you may feel you need a reminder. Remembering why we are doing something can be very helpful.

"There is no such thing as I can't. If there's a will, there's a way!"