



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, indicate what level of importance you give to losing weight via Ideal Protein's professionally 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:

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):

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 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

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 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

Are you taking any medication? Yes No

If so, please list:

Kidney Function:

Have you been diagnosed with kidney disease? 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:

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, 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
If so, please list:

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
If so, please list:

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
Are you taking any medication? Yes No
If so, please list:

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 under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

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
Are you taking any medication? Yes No
If so, please list: _____

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
Are you taking any medication? Yes No
If so, please list: _____

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
Are you taking any medication? Yes No
If so, 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, please specify and indicate for how long: _____
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 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 other medications not listed above? Yes No

If so, please list: _____

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

Vitamin, Herb or Supplement Name

Reason

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

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: _____

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 your physician.

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.

Contraindication Summary

- Severe Kidney Disease
- Severe Liver Disease
- Congestive Heart Failure
- Active Cancer (or in remission less than 3 years)
- Cardiac/Cardiovascular Event (within the last 6 months)
- History of unstable Arrhythmia
- Parkinson's Disease



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Natural Way Chiropractic Care Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We're also required to abide by the privacy policies and practices that are outline in this notice.

Uses and Disclosures:

Treatment: Your health information may be used to seek payment from your insurance plan or credit card companies that you may use to pay for services. For example, your insurance plan may request and receive information on dates of service, the services provided, and the condition being treated.

Health Care Operation: Your health information may be used to support the day-to-day activities and management of **Natural Way Chiropractic**. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality, to insure that our practice is meeting state and federal guidelines and laws designed to protect your health care information.

Law Enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandate reporting as required by law.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases and acts of abuse to state agencies.

Other Uses and Disclosures Require Your Authorization: Disclosure of your information or its use for any purpose other than those listed above requires your specific written authorization. Examples include disability forms and any letter that you request for your employer or other entity. If you change your mind after authorizing a use or disclosure of information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified our office of your change in decision.

Additional Uses of Information:

Information About Treatments: Your health information may be used to send you information on the treatment and management of your chiropractic condition that you may find to be of interest.

Natural Way Chiropractic – Bellingham
(360) 671-1710
2000 N. State Street – Bellingham, WA 98225



Appointment Reminders: Your health information will be used by our staff to send you postcards, e-mails, texts, or to call to let you know of a missed appointment and to remind you to make an appointment for a visit.

Events: Your health information will be used to remind you of upcoming events in our office.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your chiropractic condition and treatment.
- The right to inspect and copy your protected health information.
- The right to receive an accounting of how and to whom your protected health information was disclosed.
- The right to receive a printed copy of this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the address listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Privacy Officer
Natural Way Chiropractic
2000 N. State St.
Bellingham, WA 98225
(360) 671-1710

This Notice is effective on or after January 1, 2003.

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