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: _____
_____

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 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

NATURAL WAY
CHIROPRACTIC
"Healthcare for your lifestyle"

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

NATURAL WAY
CHIROPRACTIC
"Healthcare for your lifestyle"

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.