PHD WEIGHT LOSS
DOCTOR & DIETITIAN DEVELOPED, INDIVIDUALLY DELIVERED

For Office Use Only		
DLA:	No	Yes
IL:	No	Yes

Health Profile

PHD Weight Loss provides individualized nutrition consulting for weight management, optimal wellness and sports nutrition. Please consult with a physician before commencement of any dietary changes, especially if you have any health conditions or are taking medication.

Name: _____ Date: _____

How did you hear about us? _____

Best Contact Phone Number: _____ Email: _____

Address: _____City: _____State: _____Zip: _____

Date of Birth: _____Age: _____Occupation: _____

Why are you seeing us today?_____

What location will you be receiving the majority of your services? _____ ☐ Remote

Weight: _____ lbs Height: ____'____"; Do you have a Pacemaker or ICD device? ☐ Yes *(weight only)* ☐ No

(If you have a pacemaker or ICD device, you will not be performing a body composition analysis unless authorized by your physician. We will measure your weight weekly.)

Do you exercise? ☐ Yes ☐ No; If yes, what kind? _____ How often? _____

Relationship Status: ☐ Married ☐ Partner ☐ Single ☐ Divorced ☐ Widowed

Number of children: _____ Ages: _____

Please Answer Below If Weight Loss is one of your Goals:

How much do you want to weigh? _____lbs

Which of the following prevent you from reaching your desired weight? (check all that apply)

☐ Lack of Knowledge	☐ Physical Limitations	☐ Lack of Social Support	☐ Hunger
☐ Cravings	☐ Frequent Travel	☐ Social Events	☐ No Time
☐ Erratic Schedule	☐ Finances	☐ Family Habits	☐ Stress
☐ Hormonal Issues	☐ Medications	☐ Illness	☐ Poor Sleep
☐ Health Conditions	☐ Age	☐ Metabolism	☐ Alcohol
☐ No Exercise	☐ Emotional Eating	☐ Food Preferences	☐ Other

I have successfully lost weight only to regain it ☐No ☐Yes # of Times: _____

I have successfully attempted to lose weight ☐No ☐Yes # of Times: _____

Which programs have you attempted? _____

On a scale of 1-10 (10 being the highest), what is your desire to lose weight? _____

On A scale of 1-10, what is your daily stress level? _____ Source? _____

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Medical Information:

Please list your physicians and their specialty: _____

1) Diabetes:

Do you have Diabetes *(if no, skip to next section)* ☐ Yes ☐ No

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

What type of Diabetes do you have?

☐ **Type I-insulin dependent (insulin injections only)** DLA-PRIORITY
Medication for condition:_____

☐ Type II-non-insulin dependent (diabetic pills)
Medication for condition:_____

☐ **Type II-insulin dependent (diabetic pills & insulin)** DLA-PRIORITY
Medication for condition:_____

Is your blood sugar level monitored? ☐ Yes ☐ No If yes, by whom? _____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

Please Note: *If you have Type 1 or Insulin Dependent Type 2 Diabetes, it is important for your blood sugar to be carefully monitored by your healthcare provider throughout your fat loss process. Type 1 Diabetics must receive a letter of monitor from a physician prior to their PHD program. Normal blood sugar levels are 80-120 ml/dL.*

2) Cardiovascular Conditions:

Are you currently taking medication for high blood pressure? ☐ Yes DLA ☐ No

Has your doctor restricted your salt intake? ☐ Yes ☐ No

Are you taking cholesterol medication? ☐ Yes DLA ☐ No

Are you taking other heart medication? ☐ Yes DLA please list _____ ☐ No

*Anti-clot medication (Coumadin/Warafin/others) DLA-PRIORITY

Please Note: *As you slim down, medication dosages may need to be adjusted. This should be monitored by your physician. If you are taking anti-clot medication, discuss potential interactions between medication and Vitamin K (green leafy vegetables) with your physician prior to beginning your PHD Program.*

Have you had any of the following cardiovascular conditions? (Please check all that apply)

☐ **NONE**
☐ Blood Clot
☐ Pulmonary Embolism
☐ Stroke or TIA
☐ Coronary Artery Disease
☐ Heart Bypasss Surgery/Stent
☐ Heart Valve Replacement
☐ Arrhythmia/ A-fib DLA-PRIORITY
☐ Heart Attack DLA-PRIORITY
☐ Congestive Heart Failure DLA-PRIORITY

Have any of these conditions within the last 6 months? ☐ Yes[DLA-PRIORITY] ☐ No
Other conditions (Describe): _____
Please Note: If you have had a heart or circulatory event/condition within the last 6 months, we require a letter of monitor from your physician prior to beginning your PHD program.

3) Kidney Conditions: (Please check all that apply)

☐ **NONE**

☐ Kidney Disease[DLA-PRIORITY]

☐ Kidney Transplant[DLA-PRIORITY]

☐ Kidney Stones[DLA], If yes Type:_____

☐ Gout

Are you taking medication for any of these conditions? ☐ Yes[DLA-PRIORITY] ☐ No
Please Note: Consume additional water throughout your program to flush your kidneys if any of the above conditions are checked. Talk to your physician about preventive medication for gout during the first three weeks of your program.

4) Liver Conditions:

Do you have liver problems? ☐ Yes[DLA-PRIORITY] ☐ No
If so, please specify: _____

5) Colon Conditions: (Please check all that apply)

☐ **NONE**

☐ Irritable Bowel Syndrome
☐ Diverticulitis
☐ Constipation
☐ Ulcerative Colitis
☐ Crohn's Disease
☐ Diarrhea

Please Note: Inflammation from Ulcerative Colitis or Crohn's Disease could cause sensitivity to certain foods.

6) Stomach/Digestive Conditions: (Please check all that apply)

NONE

☐ Acid Reflux (GERD)
☐ Heartburn
☐ Gastric Ulcer [DLA]
☐ Bloating
☐ Nausea
☐ History of Bariatric Surgery
If so, what type of Bariatric Surgery:
_____ Date:_____

Please Note: Open ulcer sores in the stomach lining could cause sensitivity to certain foods. Any incisions made to the stomach should be healed prior to PHD program.

7) Ovarian/ Breast Conditions: (Please check that all apply)

☐ **NONE**

☐ PCOS
☐ Hysterectomy
☐ Amenorrhea
☐ Menopause

1. Are you pregnant? ☐ Yes[NE] ☐ No

2. Are you breastfeeding? ☐ Yes ☐ No

Please Note: If breastfeeding, milk supply may decrease during periods of weight loss.

8) Endocrine/Glandular Conditions: (Please check all that apply)

☐ **NONE**

☐ Thyroid problems

☐ Parathyroid problems

☐ Adrenal gland problems

9) Neurological/Emotional Conditions: (Please check all that apply)

☐ **NONE**

☐ Panic Attacks/Anxiety

☐ Depression

☐ Anorexia (history of)DLA

☐ Binge Eating

☐ Bulimia (history of)DLA

☐ Bipolar DisorderDLA-BEFORE

☐ EpilepsyDLA-PRIORITY

☐ Alzheimer's DiseaseDLA

☐ Parkinson's DiseaseDLA-PRIORITY

Are you on Lithium medication therapy for Bipolar/Mood Disorder? ☐ YesDLA-BEFORE ☐ No

Please Note: Your medication for these above conditions must be monitored by your doctor, prior to and throughout your program. If you are on lithium treatment, you will need a doctor letter prior to your PHD program. Changes in protein consumption can alter Levodopa effectiveness. Obtain a doctor letter prior to your PHD program.

10) Inflammatory Conditions: (Please check all that apply)

☐ **NONE**

☐ Migraines

☐ Psoriasis

☐ Fibromyalgia

☐ Rheumatoid Arthritis

☐ Osteoarthritis

☐ Lupus

☐ Chronic Fatigue Syndrome

☐ Multiple Sclerosis

☐ Other Autoimmune/Inflammatory Condition: _____

11) Cancer:

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If yes, what type? _____ When?_____

Is your cancer in remission? ☐ Yes ☐ NoDLA-BEFORE

Are you currently undergoing treatment? ☐ YesDLA-BEFORE ☐ No

Clients undergoing cancer treatment must receive a doctor's letter of authorization prior to their PHD Program.

Are you under treatment for breast or ovarian cancer? ☐ YesDLA-BEFORE ☐ No

Clients with current active breast/ovarian cancers must receive a doctor's letter of authorization prior to their PHD Program.

12) General:

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Please list ALL medications that you take below:

Medication:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

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

Are you a vegetarian? ☐ Yes ☐ No

Do you adhere to a strict vegan lifestyle? ☐ Yes[NE] ☐ No

13) Allergies: ☐ NONE

Do you have Celiac's Disease? ☐ Yes ☐ No

Celiac Disease is an autoimmune disease where gluten ingestion leads to damage of the small intestine.

Are you allergic or sensitive to:

Gluten	☐ Yes	☐ No
Peanuts	☐ Yes	☐ No
Soy	☐ Yes	☐ No
Dairy	☐ Yes	☐ No
Sucralose	☐ Yes	☐ No
Whey Protein	☐ Yes	☐ No

Other: _____

Please list any foods that you strongly dislike:_____

14) 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 of foods: _____

Do you have a **snack** before lunch? ☐ Yes ☐ Sometimes ☐ Never
Approx. Time: _____
Examples of foods: _____

Lunch

Do you have **lunch** every day? ☐ Yes ☐ Sometimes ☐ Never
Approx. Time: _____
Examples of foods: _____

Do you have a **snack** between lunch and dinner? ☐ Yes ☐ Sometimes ☐ Never
Approx. Time: _____
Examples of foods: _____

Dinner

Do you have **dinner** every day? ☐ Yes ☐ Sometimes ☐ Never
Approx. Time: _____
Examples of foods: _____

Do you eat a **snack** at night? ☐ Yes ☐ Sometimes ☐ Never
Approx. Time: _____
Examples of foods: _____

Other:

Do you prefer: ☐ Sweet Foods ☐ Salty Foods ☐ Fatty Foods
How many glasses of water do you drink per day? _____ oz.
How many 8oz cups of coffee do you drink per day? _____ cups

Do you drink soda? ☐ Diet ☐ Regular ☐None

Do you drink alcohol? ☐ Yes ☐ No If so, what and how often: _____

Signature: _____ Date: _____

The signatory client hereby recognizes the accuracy of the information provided herein.

Liability Disclaimer for PHD Weight Loss

I_____ give consent to PHD Weight Loss, LLC and Staff to provide wellness counseling to myself or the client for which I am responsible. I understand that PHD Weight Loss, LLC and staff are not physicians and do not dispense medical advice, nor will they diagnose any medical condition. PHD Weight Loss physician consultants will not provide direct medical care.

While weight management can be an important complement to my medical care, I understand that these services are not a substitute for medical care. Therefore, if I suspect I may have an ailment or illness that may require medical attention, I will consult a licensed physician. Only a licensed physician can prescribe medication. Any mention of medication in the course of consultation is only for the purpose of providing a complete history of medications and not for the PHD Weight Loss staff to judge the appropriateness of the medication. Any change in prescription or dosage is a decision that I make with my physician.

By signing below, I acknowledge that I understand that Dr. Lucas is a registered dietitian and she, along with her staff, are not physicians and that I should see a doctor if I think I have a medical condition. Dr. Lucas, PHD Weight Loss staff, and consulting physicians will not be held liable for failure to diagnose or treat an illness, nor will they be liable for failure to prevent future illness. This is a contract between myself, Dr. Lucas and PHD Weight Loss staff and I understand that it is a release of potential liability.

Client's Signature_____Date_____

If under the age of 18, client will need parental consent.

Parent/Guardian Signature: _____ Date: _____

PHD Weight Loss Permission for Medical Collaboration

With your permission PHD Weight Loss may need to communicate with your health care team regarding your care. Your signature authorizes us to contact your identified health care providers should we need clarification or authorization for your care.

Client Signature:_____ Date:_____