Date: _____/_____/_____/

Health Profile

Dietary consultation involves a health profile. The purpose of the health profile is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her plan. A client may be advised to seek medical advice based on his or her health profile.

1. General:

(Please use print characters)

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip/Postal Code: _____

Phone: _____ Cell: _____ Email: _____

Date of Birth: _____/_____/_____/**Age:** _____Profession: _____

Who may we thank for referring you?_____

Current Weight: _____ lbs. Height: _____ Weight 1 year ago: _____ lbs.

Minimum adult weight: _____lbs. at age _____ Maximum adult weight: _____ lbs.

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

How often? ☐ Daily ☐ Weekly ☐ Other: _____

Have you been on a diet before? ☐ Yes ☐ No If yes please specify which diet(s) and why you think it didn't work for you (example: too rigid, too much cooking involved,etc.):_____

_____

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight : (circle one)

Least important **1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** **Very/Most Important**

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

How many children do you have? _____ How old are your children? _____

Who does most of the cooking in your house? _____

On average, how many hours do you sleep per night? _____

Who is your primary care physician (family doctor)? _____

Physician List:
Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

2. Diabetes:

Do you have diabetes? ☐ Yes ☐ No (If not, please skip to next section)

Which type?

a. ☐ **Type I** - **Insulin-dependent (insulin injections only)**

b. ☐ Type II - Non-insulin-dependent (diabetic pills)

c. ☐ Type II - Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored ☐ Yes ☐ No If so, how often? _____

If so, by whom? ☐ Myself ☐ Physician ☐ Other (Please specify): _____

Do you tend to be hypoglycemic? ☐Yes ☐ No

3. Cardiovascular Function:

Have you had any of the following cardiovascular conditions?

a. ☐ **Heart Attack (NPC)**
b. ☐ **Blood Clot (NPA)**
c. ☐ **Pulmonary Embolism (NPA)**
d. ☐ **Stroke or TIA (NPA)**
e. ☐ **Coronary Artery Disease (NPA)**
f. ☐ **Heart Valve Problem (NPA)**
g. ☐ **Heart Valve Replacement – porcine / mechanical (NPA)**
h. ☐ **Arrhythmia (NPA - if on Rx medications)**
i. ☐ **Hypertension (High blood pressure) (NPA)**
j. ☐ **Hyperlipidemia (High cholesterol/triglycerides)**
k. ☐ **Hypokalemia (Low Potassium) (NPA)**
l. ☐ **Hyperkalemia (High Potassium) (NPA)**
m. ☐ **Congestive Heart Failure (NPC) –**
Please select one (if applicable):
☐ **History of Congestive Heart Failure**
☐ **Current Congestive Heart Failure (NPC)**

Have you ever had ANY type of heart surgery? ☐ **Yes** ☐ No

If so, which type? _____

Other conditions: _____

If you have answered yes to any of these conditions, please give dates of occurrence. For multiple conditions, please specify:

_____ _____
_____ _____
_____ _____

4. Kidney Function:

Have you had:
a.Kidney Stones ☐ Yes ☐ No Date: ____/____/ **c.Kidney Disease(NPA) ☐ Yes ☐ No Date: ____/____/**
b.**Kidney Transplant(NPA) ☐ Yes ☐ No**

d. Do you have Gout? ☐ Yes ☐ No If so, since when? ___/___/
If so, what medication has been prescribed? _____
If no, have you ever had Gout? ☐ Yes ☐ No If so, when? ____/____/

If yes to any of these events, please give dates of events. For multiple events please specify:

_____ _____
_____ _____
_____ _____

5. Liver Function:

a. Have you had any liver issues? (NPA) ☐ Yes ☐ No **Date: ____/____/**

If yes, please list:

_____ _____

_____ _____

6. Colon Function:

Do you have:

a. Irritable Bowel Syndrome	☐ Yes ☐ No	d. Ulcerative Colitis	☐ Yes ☐ No
b. Diverticulitis	☐ Yes ☐ No	e. Crohn's Disease	☐ Yes ☐ No
c. Constipation	☐ Yes ☐ No	f. Diarrhea	☐ Yes ☐ No

If yes to any of these events, please give dates of events. For multiple events please specify:

_____ _____

_____ _____

_____ _____

7. Digestive Function:

Do you have:

a. Acid Reflux	☐ Yes ☐ No	**e. Gastric Ulcer (NPA)**	**☐ Yes ☐ No**
b. Heartburn	☐ Yes ☐ No	**f.** Celiac Disease	☐ Yes ☐ No

c. Are you Gluten intolerant? ☐ Yes ☐ No

d. **History of Bariatric Surgery (NPA) ☐ Yes ☐ No**

If so, what type of bariatric surgery? _____

8. Ovarian/Breast Function:

Please check the situations that apply to you:

a. Irregular Periods	☐ Yes ☐ No	e. Menopause	☐ Yes ☐ No
b. Fibrocystic Breasts	☐ Yes ☐ No	f. Painful Periods	☐ Yes ☐ No
c. Hysterectomy	☐ Yes ☐ No	g. Heavy Periods	☐ Yes ☐ No
d. Amenorrhea	☐ Yes ☐ No	h. Uterine Fibroma	☐ Yes ☐ No

Date of last menstrual cycle: ____/____/____/

Are you on oral birth control pills? ☐ Yes ☐ No

i. Are you pregnant? ☐ Yes ☐ No **j. Are you breastfeeding? ☐ Yes ☐ No**

9. Endocrine Function:

a .Do you have thyroid problems? ☐ Yes ☐ No If so, please specify: _____

b. Do you have parathyroid problems? ☐ Yes ☐ No If so, please specify: _____

c. Do you have adrenal gland problems? ☐ Yes ☐ No If so, please specify: _____

Have you been told you have Metabolic Syndrome (also called "Syndrome X")? ☐ Yes ☐ No

10. Neurological/Emotional Function:

Do any of the following apply to you?

a. Bipolar Disorder	☐ **Yes** ☐ **No**	f. Panic Attacks	☐ Yes ☐ No
b. Parkinson's disease	☐ **Yes** ☐ **No**	g. Anorexia (History of)	☐ Yes ☐ No
c. Epilepsy (NPA)	☐ **Yes** ☐ **No**	h. Bulimia (History of)	☐ Yes ☐ No
d. Alzheimer's disease	☐ **Yes** ☐ **No**	i. Schizophrenia	☐ Yes ☐ No
e. Depression ☐ Yes ☐ No	**j.**	Anxiety	☐ Yes ☐ No

Other issues: _____

11. Inflammatory Conditions:

Do any of the following apply to you?

a.☐ Migraines d. ☐ Fibromyalgia f. ☐ Rheumatoid g. ☐ Lupus

b.☐ Psoriasis e. ☐ Chronic Fatigue Syndrome h. ☐ Multiple Sclerosis i. ☐ Osteoarthritis

c.☐ Other autoimmune or inflammatory condition

12. Cancer:

a. Do you have Cancer? (NPC) ☐ **Yes** ☐ **No**

If so, what type and where is it located? _____

b. Have you ever had Cancer? (NPC) ☐ If so, **Yes** ☐ **No**

what type and where is it located? _____

_ When was the Cancer diagnosed? ____/____/____/

c. Is your Cancer in remission? (NPC) ☐ **Yes** ☐ **No**

If so, how long have you been in remission? _____ (mo/yrs)

13. General:

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

If so, please specify:

_____ _____

_____ _____

14. Allergies:

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please list:

_____ _____

_____

15. 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 have a **snack** at night? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:
_____
_____
_____

Are you a vegan? ☐ **Yes** ☐ **No**

Are you a vegetarian? ☐ Yes ☐ No

How many glasses of water do you drink per day? _____ glasses per day

How many cups of coffee do you drink per day? _____ cups per day

Do you smoke? ☐ Yes ☐ No

If so, packs per day for how many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often?

_____

16. Medications

Dear Client: Please complete this form by listing all prescription medications and supplements that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet? *	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	500 mg	1	1 x a day	Dr. John Doe	Omega 3

* or grams,or dosage unit your doctor prescribes.

CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES

I confirm that the information that I have provided and that is recorded by me on this Nashville Nutrition LLC Health Profile is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

I understand that I should not be undertaking or otherwise following the Nashville Nutrition LLC guidelines if I have any serious medical conditions or if I am currently taking any medications unless
i) I specifically consult with a medical doctor concerning my suitability to start a program with Nashville Nutrition LLC,
ii) remain under the supervision of said medical doctor while I am on the Nashville Nutrition LLC program,
iii) and provide documentation confirming the foregoing.

I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to Nashville Nutrition LLC and iii) nevertheless chose to go on the Nashville Nutrition LLC program without specific supervision, such decision will be completely voluntary, and I release and discharge Nashville Nutrition LLC, its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releasees**") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision.

Without limitation to the foregoing, I confirm that I have been advised that because Nashville Nutrition LLC program limits the ingestion of certain foods, it is important that I follow my individualized plan precisely and consume the recommended vitamins and minerals**.**

I understand Nashville Nutrition LLC are not medical physicians and do not claim to diagnose, reverse or heal any ailments. I undertake to disclose immediately to Nashville Nutrition LLC any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am on the Nashville Nutrition LLC program.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules and guidelines of the American Arbitration Association, and I waive any rights to pursue any claims or causes of action in any court of law.

SIGNED _____ **Date** _____

Witness:_____