Approved____
Approved with restrictions____
Not Approved, see Dr. Matzner____

Orientation Class Date: _____ Time:_____

Individual Initial Consultation Date:_____ Time:_____ Coach: _____

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: _____

Home Phone:_____ Cell: _____ Work Phone: _____

E-mail: _____ Profession:_____ Employer: _____

Date of Birth: _____ Age:_____ Sex: _____ Preferred Language: _____

Race (Circle One): American Indian or Alaska Native/ Asian/ Black or African American/ White or Caucasian/ Native Hawaiian or Pacific Islander/ Other/ I Decline to Answer
Ethnicity (Circle One): Hispanic or Latino/ Not Hispanic or Latino/ I Decline to Answer

Weight:_____ Weight 1 year ago: _____ Min. Adult Weight: _____ at age _____

Max. Weight: _____lbs. at age _____ Height: _____ Goal Weight: _____ (BMI _____)

Do you exercise? ☐ Yes ☐ No If yes, what kind, how often, and what intensity?

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's medically supervised weight loss method (10 being the most important): _____

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: _____

Who does most of the cooking in your house? _____

On average, how many hours of sleep do you get at night? _____

Physicians List

Please list any physicians you see and their specialty:

Dr. _____ Specialty: _____ Patient Since: _____

Dr. _____ Specialty: _____ Patient Since: _____

Dr. _____ Specialty: _____ Patient Since: _____

Dr. _____ Specialty: _____ Patient Since: _____

Do you see a Chiropractic Physician? _____ If so, who? _____

Have you had blood work done within the last 12 months? ☐ Yes ☐ No

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 be hypoglycemic? ☐ Yes ☐ No

Cardiovascular Health:

Have you had ANY cardiovascular event or surgery? ☐ Yes ☐ No
If so, please specify: _____
How long ago? _____

Do you have a history of arrhythmia? ☐ 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

Kidney Health:

Have you had:
Kidney disease? ☐ Yes ☐ No
Kidney stones? ☐ Yes ☐ No
Kidney transplant? ☐ Yes ☐ No
Gout? ☐ Yes ☐ No

Liver Health:

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

If so, please specify: _____

Colon Health

Do you have: ☐ None of these (skip to next section)

☐ Irritable Bowel ☐ Colitis ☐ Diarrhea ☐ Diverticulitis ☐ Crohn's ☐ Constipation

Stomach/Digestive Health:

Do you have: ☐ None of these (skip to next section)

☐ Acid Reflux ☐ Gastric Ulcer ☐Heartburn ☐ Celiac Disease ☐ Bariatric Surgery

Ovarian/Breast Health: (Men skip to next section)

Check off the situations that apply to you currently: ☐ None (skip to next section)

☐ Irregular periods ☐ Menopause ☐ Fibrocystic Breasts ☐ PCOS

☐ Painful Periods ☐ Hysterectomy ☐ Heavy periods ☐ Uterine fibroma

☐ Amenorrhea ☐ Cancer (uterus, breast)

The last menstrual cycle: _____ Are you on oral birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Endocrine Function

Do you have thyroid problems? ☐ Yes ☐ No

Do you have parathyroid problems? ☐ Yes ☐ No

Do you have adrenal gland problems? ☐ Yes ☐ No

If so, please specify: _____

Emotional Evaluation

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

☐ Depression ☐ Anxiety/Panic Attacks ☐ Bulimia (or history of)

☐ Anorexia (or history of) ☐ Bipolar Disorder ☐ Epilepsy

☐ Alzheimer's disease ☐ Parkinson's disease ☐ Schizophrenia

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

☐ Migraines ☐ Multiple Sclerosis ☐ Rheumatoid Arthritis ☐ Lupus

☐ Osteoarthritis ☐ Chronic Fatigue Syndrome ☐ Psoriasis ☐ Fibromyalgia

☐ Other autoimmune or inflammatory condition _____

Bone and Joint

Do you currently experience any of the following: ☐ None of these (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

If so, please specify what type and where: _____

If so, please specify when you were diagnosed: _____

Are you in cancer remission? ☐ Yes ☐ No

If so, please specify and indicate for how long: _____

General

Are you generally fatigued or have low energy? ☐ 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: (recent surgeries, etc..)_____
_____
_____

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:
_____

Medications and Supplements

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

Name of Medication	How many mg is each?	How many tablets per day?	How often do you take them?	Prescribed by whom?	Why do you take this?
Vitamin X	500mg	2	Once daily	Dr. John Doe	Omega-3

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 (mark as many as needed): ☐ Sweet foods ☐ Salty foods ☐ Fatty foods
Are you a vegetarian? ☐ Yes ☐ No Are you a vegan? ☐ Yes ☐ No
How much pop do you drink per day? _____ How much of water do you drink per day? _____
How many cups of coffee do you drink per day? _____Caffeinated Cups ____Decaffeinated Cups
How many cups of tea do you drink per day? _____Caffeinated Cups ____Decaffeinated Cups
Do you drink other non-alcoholic drinks daily? _____
Do you smoke? ☐ Yes ☐ No Have you ever been a smoker? ☐ Yes ☐ No
If yes, how many packs/day?____ For how many years?_____ Would you like to quit? ☐Yes ☐No
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.

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 seconds 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 are taking medications, are you interested in getting off any or all of your prescription medications? ☐ Yes ☐ No ☐ N/A

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.

----------For Office Use Only----------

Dr. Letter Sent _____ Welcome Letter Sent _____ MacP # _____

BW: Brought In ___/___/____ Requested on ___/___/____ Received on ___/___/___

Need Dr. Approval: ___ Dr. Approval Received: ___/___/____

Dx Code(s): _____ DM Notes: _____

MATZNER CLINIC
Jump Start Weight Loss™

Matzner Clinic
1712 S. Duncan Road, Suite B
Champaign, IL 61822
Douglas Matzner, D.C., F.I.A.C.A. Director*
(217) 359-6625
www.matznerclinic.com
*DBA Matzner Clinic of Chiropractic Medicine

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

1. Matzner Clinic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Matzner Clinic to provide treatment to me, and also necessary for Matzner Clinic to obtain payment for that treatment and to carry out health care operations. Matzner Clinic has explained to me that the Privacy Notice will be available to me in the future at my request. Matzner Clinic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. Matzner Clinic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by Matzner Clinic: a) a postcard mailed to me at the address provided by me; and b) telephoning my home or cell phone and leaving a message on my answering machine or with the individual answering the phone. I also understand that Matzner Clinic acknowledges those who refer with a thank you.

4. Matzner Clinic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Matzner Clinic to treat me and obtain payment for that treatment, and as necessary for Matzner Clinic to conduct its specific health care operations.

5. I understand that I have a right to request that Matzner Clinic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Matzner Clinic is not required to agree to any restrictions that I have requested. If Matzner Clinic agrees to a requested restriction, then the restriction is binding on Matzner Clinic.

6. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Matzner Clinic has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, Matzner Clinic has the right to refuse to treat me.

7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, by Federal law Matzner Clinic has the right to not treat me.

8. I understand that the terms of this notice may change. Any revised updates will be posted to the Matzner Clinic website for my information and review.

   I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Matzner Clinic.

   I understand that the Notice describes the uses and disclosures of my protected health information by Matzner Clinic and informs me of my rights with respect to my protected health information.

Patient's Signature or that of Legal Representative	*Printed Name of Patient or that of Legal Representative*
Today's Date	*If Legal Representative, Indicate Relationship*

Witness

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

Employee Name	*Today's Date*