Health Status Intake Form

Date: _____

Last Name: _____ First Name: _____ D.O.B: _____

Address: _____City: _____ ST: _____ZIP_____

Phone: _____ Cell:_____ Email: _____

Age: _____ HT: _____ WT:_____ BMI:_____ Fat %: _____

Occupation: _____ Sex: M☐ F☐ Marital Status: M☐ S☐ D☐ W☐

How did you hear about the ITG Diet? _____

Do you have children? Yes☐ No☐ Ages of children: _____

Your Goals/Challenges/Support

Why do you want to lose weight? _____

What have been your challenges losing weight in the past? _____

_____

What other diets have you been on before:_____

Do you have family or a friends support to go on a plan? Yes☐ No☐

Who and relationship: _____

Hours sleeping: _____ Hours working:_____ Exercise program: Yes☐ No☐

Exercise Frequency: Daily☐ 1-2 days/wk☐ 3-5 days/wk☐ 6-7days/wk☐ Never☐

Current level of stress, scale of 1-10 (10 being High): _____

How motivated are you to improve overall health and lose weight, scale of 1-10? _____

What are your goals? Goal Weight_____ Goal BMI_____ Goal Fat %_____

Do you have a partner or friend who would like to start the plan with you? Yes☐ No☐

If yes, who: _____

Medical Information (If no on any of these issues check NA and skip to next section)

Diabetes/Hypoglycemic

NA ☐

Type 1 ☐ Insulin dependent (injections only)
Type 2 ☐ Could be insulin and/or oral medication

Are you under the care of a physician? Yes ☐ No ☐

If so, Name of the Physician: _____
Phone:_____

Are you Hypoglycemic: Yes ☐ No ☐
Diabetic medications:

Medication	Dosage	X/Day	Notes

Cardiovascular

NA ☐

☐ Arrhythmia
☐ Blood Clots
☐ Congestive Heart Failure
☐ Heart Attack
☐ Heart Surgery
☐ Heart Valve Problem
☐ High Cholesterol
☐ Hypertension (High Blood Pressure)
☐ Stroke or TIA

If any of the events above, please give more details and date of each event.

_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Liver & Kidney Functions

NA ☐

Do you have any kidney problems? Yes ☐ No ☐
Do you have any liver problems/high liver enzyme levels? Yes ☐ No ☐
If yes, please explain_____
_____

Have you had any of the following?

☐ Kidney Disease
☐ Kidney Stones
☐ Kidney Transplant
☐ Fatty Liver
☐ Cirrhosis of the Liver
☐ Renal Failure

If any of the events above, please give more details and date of each event.
_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Colon Function

NA ☐

Do you have any of the following?

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

If any of the events above, please give more details and date of each event.
_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Digestive Functions

NA ☐

Do you have any of the following?

- ☐ Acid Reflex
- ☐ Gastric Ulcer
- ☐ Heartburn
- ☐ Bariatric Surgery
- ☐ Lap Band Surgery
- ☐ Other

If any of the events above, please give more details and date of each event.

_____
_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Inflammatory Conditions

NA ☐

Do you have any of the following?

- ☐ Arthritis
- ☐ Chronic Fatigue
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Migraines
- ☐ Psoriasis
- ☐ Other

If any of the events above, please give more details and date of each event.

_____
_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Cancer

NA ☐

Do you have cancer? Yes ☐ No ☐
Have you ever had cancer? Yes ☐ No ☐
Are you in remission? Yes ☐ No ☐

If you have had cancer please give details and dates below:

_____
_____
_____
_____

Medications

Medication	Dosage	X/Day	Notes

Emotional Evaluation

NA ☐

Do you have any of the following?

☐ Anorexia
☐ Anxiety
☐ Bipolar Disorder
☐ Bulimia
☐ Depression
☐ Drug Addiction
☐ Panic Attacks
☐ Schizophrenia
☐ Other

If any of the events above, please give more details and date of each event.

_____
_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Pulmonary Issues

NA ☐

Do you have any of the following?

☐ Asthma
☐ COPD
☐ Chronic Bronchitis
☐ Emphysema
☐ Cystic Fibrosis
☐ Other

If any of the events above, please give more details and date of each event.

_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Other Conditions

NA ☐

Do you have any of the following?

☐ Alzheimer's
☐ Parkinson's
☐ Multiple Sclerosis
☐ Hypothyroidism
☐ Seizures
☐ Other

If any of the events above, please give more details and date of each event.

_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

For Women Only NA ☐

Do you have any of the following?

☐ Fibrocystic Disease
☐ Hysterectomy
☐ Irregular Periods
☐ Menopause
☐ Polycystic Ovary Syndrome (PCOS)
☐ Uterine Fibroids

Date of your last Menstrual Cycle_____

Are you Pregnant? Yes ☐ No ☐ Are you breastfeeding? Yes ☐ No ☐

If any of the events above, please give more details and date of each event.

_____
_____
_____

Medications for any of the above:

Medication	Dosage	X/Day	Notes

Please note - Rapid weight loss may cause an increase in the level of estrogen in the bloodstream. This in turn may possibly affect menstrual cycle regularity, change PMS symptoms, and or increase fertility. Please contact your OB-GYN if you have any concerns or questions. It is recommended when on the plan to use an alternative birth control method if on oral contraceptives.

General Questions

Do you have any allergies? Yes ☐ No ☐ Explain if yes:

_____
_____

Are you a Vegetarian? Yes ☐ No ☐ Are you a Vegan? Yes ☐ No ☐

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

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

Do you drink alcohol? Yes ☐ No ☐ If yes, what do you normally drink and how often?

_____

Please explain what you normally eat in a day:

Breakfast: What time to do you eat Breakfast? _____

_____

Lunch: What time to do you eat Lunch? _____

_____

Dinner: What time to do you eat Dinner? _____

_____

Snack: What time to do you eat Snacks? _____

_____

What supplements do you currently take? Please list below:

Supplement	Dosage	X/Day	Notes

Please list your Primary Care Physician and any other physicians that you see on a regular basis:

Physician	Specialty	City	Phone number

Any other comments about your overall health? List below:

_____

_____

_____

_____

Informed Consent for ITG Diet Weight Control Plan

I affirm that the information on this Health Status Intake Form is complete and accurate and I have disclosed any medical conditions that may be contraindications to go on the ITG Diet weight loss plan. _____ (please initial here)

I understand that I must take the supplements that are provided by ITG while I am on the ITG Diet weight loss plan. _____ (please initial here)

Consent to participate:
I hereby consent to act as a participant in a weight control plan involving the use of protein and other supplements. I understand that various employees may provide this to me.

If I have any questions about this or need further explanations, I understand that I should speak with my medical provider before starting any weight loss program.

I have been informed that the possible benefit and value of this treatment is not guaranteed. I understand that there are many alternative treatments or procedures that are appropriate and available that might be beneficial to me. Some of those alternatives or choices include but may not be limited to:

1. No treatment at all.
2. Conservative lifestyle changes.
3. Drugs.
4. Surgery.
5. Watch and wait, while reporting my condition to a physician.

I understand that I have the right not to participate in this plan or to discontinue it after I have begun, for any reason whatsoever. I understand that I have the right to ask questions and to know the purpose and objectives of my weight loss plan.

Having read this page, I hereby consent to this plan. I have had adequate time to ask any questions and understand the answers provided. At this time I have no other questions, but I am aware that any future questions may be posed and will be responded to in a timely fashion.

Dieter Name _____

Dieter Signature _____ Date _____

Coach Signature _____ Date _____

The Inner Diet™

Pre-assessment document

At **ITG Diet** we are interested in more than simply helping you to lose weight. We are also interested in helping you learn how to make better eating decisions and stop yo-yo dieting. Before we get started, however, we would appreciate your answers to the following questions. There are no right or wrong answers so simply respond with the answer that is most true for you. We're glad you've come to see us.

1. Have you ever successfully lost weight only to regain that weight over time?

Yes_____ No_____ If Yes, how many times_____

2. Changing the way that you eat takes both "mental "and "physical" change and discipline.

☐ Strongly Agree ☐ Slightly Agree ☐ Agree ☐ Disagree ☐ Slightly Disagree ☐ Strongly Disagree

3. What role does the "mind" play in successful weight management?

☐ Very Significant ☐ Slightly Significant ☐ Significant ☐ Insignificant ☐ Slightly Insignificant ☐ Very Insignificant

4. What percent of successful weight management involves changing the way you think?

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

5. I am an "emotional eater". I eat when I am upset, angry, sad, etc.

☐ Strongly Agree ☐ Slightly Agree ☐ Agree ☐ Disagree ☐ Slightly Disagree ☐ Strongly Disagree

6. Your chances for success would increase if you understood more about "why" you overeat?

☐ Strongly Agree ☐ Slightly Agree ☐ Agree ☐ Disagree ☐ Slightly Disagree ☐ Strongly Disagree

7. Would you like to learn more about "why" you overeat?

Yes_____ No_____