Health and Wellness Profile

How did you hear about us?

Referral? ☐ By Who?_____
Facebook ☐ Instagram ☐ YouTube ☐ Commercial ☐
Google ☐ What did you Search? _____

Personal Information

First Name_____ Last Name_____ DOB _____

Home Phone _____ Cell _____ Email _____

Address _____ Apt/Unit _____

City, State, Zip _____

Profession _____ Travel for work? ☐ YES ☐ NO How often?_____

What does your typical work lunch look like? _____

What time do you go to work? _____ Get off work? _____

Do you work nights/Weekends? ☐ YES ☐ NO Hours? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children? ☐ YES ☐ NO If yes, # of children _____ Do they currently live with you? ☐ YES ☐ NO

What are their ages? _____

On a scale from 1 (unhealthy) to 10 (very healthy), rate the following:

Stress _____ Diet _____ Movement _____ Sleep _____

Do you have troubles sleeping ☐ YES ☐ NO

Staying asleep? ☐ YES ☐ NO Falling asleep? ☐ YES ☐ NO Wake up refreshed? ☐ YES ☐ NO

Do you have sleep apnea? ☐ YES ☐ NO

Do you use any sleep aids, medications, herbal medicine? ☐ YES ☐ NO

If yes, please specify _____

Would you consider your daily activity:

☐ Sedentary ☐ A little Active ☐ Active ☐ Extremely Active

Do you exercise? ☐ YES ☐ NO If yes, what kind? _____

Glasses of water per day? _____ Do you flavor your water? ☐ YES ☐ NO

What kind of flavoring? _____ How often? _____

Do you drink coffee? ☐ YES ☐ NO Caffeine cups per day? _____ Decaf per day? _____

Black? ☐ Creamer? ☐ _____ Sweetener? ☐ _____

Do you drink tea? ☐ YES ☐ NO If yes, how much and what kind? _____

Do you drink soda pop? ☐ YES ☐ NO If, yes how much and what kind? _____

Do you drink energy drinks? ☐ YES ☐ NO If yes how much and what kind? _____

Do you drink alcohol? ☐ YES ☐ NO What kind? _____

How many drinks per week? _____

Are you able to stop drinking to lose weight? ☐ YES ☐ NO

Daily Diet Section

Are you a stress eater? ☐ YES ☐ NO

If yes, are you Emotional? ☐ YES ☐ NO Impulsive? ☐ YES ☐ NO

Rate your stress level on a scale of 1-10 for the following categories (10 being high stress):

Work _____ Family/Relationships _____ Finances _____ Health ____Self Related _____

What do you feel are your personal triggers (check all that apply)?

☐ Stress ☐ Boredom ☐ Anxiety ☐ Surroundings ☐ Emotions ☐ N/A

Which do you prefer? ☐ Sweet foods? ☐ Salty foods? ☐ Fatty foods?

Do you have any food allergies or sensitivities? ☐ YES ☐ NO

List all that apply: _____

Do you eat animal proteins? ☐ YES ☐ NO

What kinds? _____ How often/week? _____

Are there any proteins you will not eat? _____

Do you eat vegetables? ☐ YES ☐ NO Daily? ☐ YES ☐ NO

Are there any vegetable you will not eat? _____

Do you like healthy fats? ☐ YES ☐ NO

Are there any healthy fats you will not eat? _____

Do you eat fruit? ☐ YES ☐ NO Daily? ☐ YES ☐ NO

Any fruits you will not eat? _____

Eating Patterns

Have you heard of Fasting? ☐ YES ☐ NO

If yes, do you currently fast? ☐ YES ☐ NO

How often? _____ How long? _____

Who does most of your cooking in your household? _____

Do you currently have a meal plan? ☐ YES ☐ NO Meal Prep? ☐ YES ☐ NO

How many meals do you eat out a week? _____

What places do you eat out regularly? _____

Examples of what you like to order: _____

Do you eat on the go? ☐ YES ☐ NO if yes, how many times per week? _____

Do you pack food from home? ☐ YES ☐ NO

If no, what are you go-to places for on the go? _____

What do you typically eat on the go? _____

Have you dieted before? ☐ YES ☐ NO

What diets have you tried? _____

_____

Did they work for you? ☐ YES ☐ NO Why or why not? _____

_____

On a scale of 1-10 (10 being the highest):

How important is losing weight to you? _____ improving overall health? _____

Explain what prompted you to call us? _____

Medical Information

Was it suggested by your physician that you lose weight to improve your health? ☐YES☐NO

Physician Name? _____

Have you had any invasive surgery for fat loss? ☐ YES ☐ NO Body Sculpting? ☐ YES ☐ NO

If yes, please specify: _____

Was it successful? ☐ YES ☐ NO ☐ N/A

Any non-invasive fat loss treatments? ☐ YES ☐ NO Body Sculpting? ☐ YES ☐ NO

If yes, please specify: _____

Was it successful? ☐ YES ☐ NO ☐ N/A

Have you heard of Red/Near Infrared Light Therapy? ☐ YES ☐ NO

If yes, have you used it before? ☐ YES ☐ NO Specify when _____

Have you heard of EmSculpt NEO? ☐ YES ☐ NO

If yes, have you used it before? ☐ YES ☐ NO

Specify when and what areas _____

Did you feel like it was successful? ☐ YES ☐ NO

DIABETES

Do you have diabetes? ☐ YES ☐ NO

If NO, please skip this section

If yes, which type:

_____ Type I: Insulin-Dependent (insulin injections only) TYPE 1 - MUST DO FLEX DIABETIC PLAN

_____ Type II: Non-dependent (diabetic pills)

_____ Other: Insulin-dependent (diabetic pills & insulin)

Is your blood sugar level monitored? ☐ YES ☐ NO If yes, how often? _____

By whom? _____ Self _____ Physician _____ Other Please specify _____

ENDOCRINE FUNCTION

Do you have thyroid problems? ☐ YES ☐ NO

If NO, please skip this section

_____ Hypo _____ Hyper _____ Hashimoto's

If yes, please specify:

_____

Do you have parathyroid problems? ☐ YES ☐ NO

If yes, please specify:

_____

Do you have adrenal gland problems? ☐ YES ☐ NO

If yes, please specify:

_____

Have you been told you have Metabolic Syndrome? ☐ YES ☐ NO

CANCER

Do you have cancer? ☐ YES ☐ NO

If NO, please skip this section

If yes, what type and where: _____

Have you ever had cancer? Y ☐ YES ☐ NO

If yes, what type and where: _____

Is your cancer in remission? ☐ YES ☐ NO

If yes, how long: _____

CARDIOVASCULAR

Do you have any of the following conditions? NONE ☐

Arrhythmia ☐ YES

Blood Clot ☐ YES

Coronary Artery Disease ☐ YES

Heart Attack? ☐ YES IF yes, When? _____

Heart Valve Problem ☐ YES

Heart Valve Replacement ☐ YES

Pacemaker or Defibrillator ☐ YES

Hyperlipidemia ☐ YES

Pulmonary Embolism ☐ YES

Stroke or Transient Ischemic Attack ☐ YES

Current Congestive Heart Failure ☐ YES

History of Congestive Heart Failure ☐ YES ☐ NO If yes, hen? _____

Have you had any type of heart surgery? ☐ YES ☐ NO If yes, which type: _____

Hyperkalemia (high potassium) ☐ YES

Hypokalemia (low potassium) ☐ YES

Hypertension (high blood pressure) ☐ YES

Do you check your blood pressure regularly? ☐ YES ☐ NO How often? _____

Are you currently taking any Blood Pressure medications? ☐ YES ☐ NO

Has your physician restricted your sodium intake? ☐ YES ☐ NO

LIVER FUNCTION

Have you ever had any liver conditions? ☐ YES ☐ NO Date: _____

If NO, please skip this section

If yes, please list:

_____

Have you ever had a gallstone incident? ☐ YES ☐ NO

Do you still have your gallbladder? ☐ YES ☐ NO

KIDNEY FUNCTION

Have you had any of the following conditions?

Kidney Disease (NPA) ☐ YES ☐ NO

Kidney Stones ☐ YES ☐ NO If yes, when was your last episode? _____

How was it resolved? _____

Kidney Transplant ☐ YES ☐ NO If yes, when? _____

Do you presently have gout? ☐ YES ☐ NO If yes, since when? _____

If yes, what medication has been prescribed? _____

Have you ever had gout? ☐ YES ☐ NO If yes, when? _____

COLON FUNCTION

Do you have any of the following conditions? NONE ☐

Constipation (occasional or chronic) ☐ YES

Diverticulitis ☐ YES

Ulcerative Colitis ☐ YES

Diarrhea (occasional or chronic) ☐ YES

Crohn's Disease ☐ YES

Irritable Bowl Syndrome ☐ YES

DIGESTIVE FUNCTION

Do you have any of the following conditions? NONE ☐

Acid Reflux ☐ YES

Gastric Ulcer ☐ YES

Gluten Intolerance ☐ YES

Celiac Disease ☐ YES

Heartburn ☐ YES

Bariatric Surgery ☐ YES If yes, what type & when? _____

OVARIAN/BREAST FUNCTION

Do you have any of the following conditions? NONE ☐

Amenorrhea (no menstruation) ☐ YES

Heavy Periods ☐ YES

Menopause ☐ YES

Irregular Periods ☐ YES

Uterine Fibroma ☐ YES

Fibrocystic Breasts ☐ YES

Hysterectomy ☐ YES

PCOS ☐ YES

Date of last menstrual cycle: _____ Taking oral contraceptives? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Are you breast feeding? ☐ YES ☐ NO

NEUROLOGICAL/EMOTIONAL FUNCTION

Do you have any of the following conditions? NONE ☐

Alzheimer's Disease ☐ YES

Epilepsy ☐ YES

Bulimia (history of) ☐ YES

Parkinson's Disease ☐ YES

Depression ☐ YES

Panic Attacks ☐ YES

Schizophrenia ☐ YES

Anorexia (history of) ☐ YES

Bipolar Disorder ☐ YES

Anxiety ☐ YES

Other:

_____

INFLAMMATORY CONDITIONS

Do you have any of the following conditions? NONE ☐

Multiple Sclerosis ☐ YES

Migraines ☐ YES

Fibromyalgia ☐ YES

Rheumatoid Arthritis ☐ YES

Osteoarthritis ☐ YES

Sarcoidosis ☐ YES

Chronic Fatigue Syndrome ☐ YES

Lupus ☐ YES

Psoriasis ☐ YES

Have you had any other type of surgery not listed? ☐ YES ☐ NO

Specify _____

_____

Do you have any past injuries not listed? ☐ YES ☐ NO

Specify _____

_____

Do you suffer from any pain or inflammation from a past injury? ☐ YES ☐ NO

Specify _____

_____

Medications and Supplements

Name	Mg per capsule	# of capsules/day	# of doses/day	Prescribing Dr.	Reasoning

I, _____(initial) recognize that LosingiT! is a weight-loss program and any information provided by LosingiT! is for my knowledge only and does not substitute for professional medical advice. I declare that I have not, and will not, rely on any information provided to me by LosingiT! or its consultants, staff or representative as an alternative to medical advice from my doctor or professional healthcare provider.

I, _____(initial) acknowledge and agree that I am aware of such risks and that participation in the LosingiT! Program is voluntary. Participating may result in exposure to allergens, and in that regard and assuming such known or unknown risks, I hereby full release and discharge the released parties from all liability and/or responsibility to the indirect, disciplinary, incidental or any damages that arise out of or related to participation in or any exposure to food allergens while participating in the Losing It! program. As a client, I am responsible for making myself aware of all original package labeling.

I certify that I have read this entire document.

My signature below indicates that the information on the Health and Wellness Profile is accurate and current. Including all medications, allergies, and any health conditions. I, as the client, am responsible for reading labels to know what I can and cannot consume.

Client signature: _____Date: _____