Weight Loss

blueprint to Weight Loss

PERSONAL INFORMATION

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone *(Home)* _____ *Mobile* _____

Email _____ **Date of Birth** _____

Age _____ **Height** _____ **Occupation** _____

Who may we thank for referring you to our office?

Friend or Family _____ **Health Care Provider** _____

Online Search _____ **Wellness Class** _____ **Other** _____

MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family

☐ Depression	☐ Brain fog	☐ Headache
☐ Heart Attack	☐ Hypoglycemia	☐ Neuropathy/nerve problems
☐ Diabetes	☐ Anemia	☐ Poor Sleep
☐ Thyroid Disease	☐ Cancer	☐ Dizziness
☐ Gallbladder Disease	☐ High Blood Pressure	☐ Arthritis
☐ Kidney Disease	☐ Intestine Problems	☐ Weight gain
☐ Stroke	☐ Shortness of Breath	☐ Back Pain
☐ Fatigue	☐ High Cholesterol	☐ Carpal Tunnel

Is there a certain time of day any of these problems are better or worse? _____

_____

Are you taking any medications/supplements? _____ If Yes, please list _____

_____

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

Are you breast feeding? _____

Any known allergies? _____ If Yes, please list _____

_____

Main Concerns:

1. _____ 2. _____

3. _____ 4. _____

How long have you had this/these concerns? _____

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What effect does this have on your body functions or quality of life? _____

_____

What would be different or better without this/these concerns?

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other _____

How did the previous methods work for you? _____

What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

Do you feel it possible to eliminate or prevent these potential barriers? _____

What outcome would you like to see for this to be a success for you? _____

_____

_____

Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I am interested in:

Weight loss ☐ ***Inch Loss*** ☐ ***Anti-Aging*** ☐ ***Metabolism Support*** ☐

Long Term Results ☐

Thank you

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire

	None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Moderate	Severe
Asthma, hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____

CANDIDA QUESTIONNAIRE

Add up the points for the answer to each question below. Once you have your total, read the key below to better understand your current candida overgrowth situation.

QUESTIONS	YES	NO
1. Have you taken repeated or prolonged courses of antibacterial drugs?	4	0
2. Have you been bothered by recurrent vagina, prostate or urinary infections?	3	0
3. Do you feel "sick all over," yet the cause hasn't been found?	2	0
4. Are you bothered by hormone disturbances? *(including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature, or fatigue)*	2	0
5. Are you unusually sensitive to tobacco smoke, perfumes, and other chemical odors?	2	0
6. Are you bothered by memory or concentration problems?	2	0
7. Have you taken prolonged courses of prednisone or other steroids?	1	0
8. Have you taken birth control for more than 3 years?	1	0
9. Do you suffer with constipation, diarrhea, bloating or abdominal pain?	1	0
10. Does your skin itch, tingle or burn, is it unusually dry; or are you bothered by rashes?	1	0
11. When you wake up, do you have a white coating on your tongue?	1	0
TOTAL		

WOMEN

A score of 10 or greater indicates that your health problems may be connected to a Candida overgrowth.

A score of 13 or higher suggests that your symptoms are very likely to be related to Candida.

MEN

A score of 8 or greater indicates that your health problems may be connected to a Candida overgrowth.

Adrenal Fatigue Test

Check all the boxes that apply to you.
Add up the total and place in the box below.

- ☐ I am frequently tired.
- ☐ I feel tired even after 8 to 10 hours of sleep.
- ☐ I am chronically stressed.
- ☐ It is difficult for me to handle stress.
- ☐ I am a night-shift worker.
- ☐ I work long hours.
- ☐ I have little relaxation time during my days.
- ☐ I get headaches frequently.
- ☐ I don't exercise consistently.
- ☐ I am or have been an endurance athlete (or participate in CrossFit).
- ☐ I have erratic sleep patterns.
- ☐ I wake up in the middle of the night.
- ☐ I crave salt.
- ☐ I have high sugar intake.
- ☐ I have difficulty concentrating.
- ☐ I carry weight in my midsection (an apple-shape body).
- ☐ I have low blood sugar issues (hypoglycemia).
- ☐ I have irregular periods.
- ☐ I have a low libido.
- ☐ I have PMS or perimenopausal/menopausal symptoms.
- ☐ I get sick frequently.
- ☐ I have low blood pressure.
- ☐ I have muscle fatigue or weakness.
- ☐ I rely on caffeine for energy (coffee, energy shots, etc.).

Total: ☐