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 Other:_____

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

Other Conditions NA_____

Do you have any of the following?

_____ Alzheimer's
_____ Parkinson's
_____ Multiple Sclerosis
_____ Hypothyroidism
_____ Hyperthyroidism
_____ 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:

_____

Lunch:

_____

Dinner:

_____

Snack:

_____

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

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 _____