BioFXN
Personalized Innovative Healthcare

Dr. Anna Martin, ND
*Functional Medicine Doctor*

*Powered by Rebound SportsMed*

## Health Profile

Our program is intended to help participants with their personal weight loss efforts.

**General:** Date:_____

***Last Name:*** _____ ***First Name:*** _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Best Contact Phone Number: _____ ***Email:*** _____

Date of Birth: _____Age: _____Profession: _____

**Whom may we thank for referring you:** _____

Weight: _____ lbs Height: ____ft_____inches

***How much do you want to weigh?*** _____

Do you exercise? ☐ Yes ☐ No If yes, what kind? _____

How often? _____

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.): _____

On a Scale of 1-10, indicate what level of importance you give to losing weight (10 being the most important)? #____

On a Scale of 1-10, what is the level of stress in your life (10=maximum stress)? #_____

Do you sleep well and wake up rested? Y / N

Have you been diagnosed with sleep apnea? Y / N

Do you have pain anywhere in your body? (If yes, please list problem area of pain): _____

_____

## 2) Cardiovascular Function (Heart and Vascular Conditions) (Con't):

Have you ever had ANY type of heart surgery? ☐ Yes ☐ No
If so, which type? _____
Other conditions: _____
If you have answered yes to any of these conditions, please give dates of occurrence: _____
_____

## 3) Kidney Function:

a. Have you been diagnosed with kidney disease? ☐ **Yes** C-L ☐ No
b. Have you ever had kidney transplant? ☐ Yes L ☐ No
Are you taking any medication for this condition? ☐ Yes ☐ No
Please list and medication you are taking for these conditions: _____
_____

c. Have you ever had Kidney Stones? ☐ Yes C ☐ No
d. Have you ever had Gout? ☐ Yes C ☐ No

## 4) Liver Function:

a. Do you have liver problems? ☐ Yes C-L ☐ No
If so, please specify: _____

## 5) Colon Function:

Do you have: ☐ NONE

a. ☐ Irritable Bowel Syndrome
b. ☐ Diverticulitis
c. ☐ Constipation
d. ☐ Ulcerative Colitis C
e. ☐ Crohn's Disease C
f. ☐ Diarrhea

If yes to any of these conditions, please give dates of events: _____
_____

## 6) Stomach/Digestive Function:

Do you have any of the following conditions? ☐ NONE

a. ☐ Acid Reflux
b. ☐ Heartburn
c. ☐ Gastric Ulcer C-L
d. ☐ History of Bariatric Surgery C-L
If so, what type of Bariatric Surgery:
_____

## 12) General:

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Do you take any other medications? ☐ Yes ☐ No

If so, please specify: _____

Are you currently taking any Vitamins, Herbs or Supplements? ☐ Yes ☐ No

| | Vitamin, Herb or Supplement Name | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Are you a vegetarian? ☐ **Yes** ☐ No

Do you adhere to a strict vegan lifestyle? **Yes** ☐ No ☐

## 13) Allergies:

☐ **NONE**

Are you gluten intolerant? ☐ Yes ☐ No

Do you have Celiac's Disease? ☐ Yes ☐ No

Are you allergic to Peanuts ☐ Yes ☐ No

Soy ☐ Yes ☐ No

Dairy ☐ Yes ☐ No

Do you have any *Food* allergies? ☐ Yes ☐ No

If so, please list: _____

## CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger

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. You:

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

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**Signature:** _____ **Date:** _____

The signatory client hereby recognizes the accuracy of the information provided herein.