Personal Health Summary

The EMP 180°™ program was created to help individuals improve their health by helping them to lose weight. We are not a medical practice or organization, and our staff cannot provide any medical or psychological advice. It is advisable to seek professional (medical) advice prior to initiating a new regimen, especially if you have any health situations and/or taking medication.

First Name:_________________________Last Name: ___________________________ Date:_______________

Address:____Apt/Unit #: ____________________________

City:____State:___________Zip: ________________

Best Contact Number:_________________________________Voicemail okay? __________________

Email:____Date of Birth:________________Age: _______

Profession: ____

Weight:_______lbs.   Height:___ft.____in.   What weight would you like to be? _________________

How did you hear about us? ___________________

Family Life:

Marital Status: **M   S   D   W**

Children (Grandchildren):_____(_____) Ages:____________________________(________________________)

Exercise and Personal Habits:

Do you exercise? Y / N   If yes, what kind(s)? ____

____

____

How frequent day/week?_______________________________Minutes day? ___________________________

Have you attempted to lose weight before? Y / N

If yes, please specify which diet program and why you think it didn't work for you (poor or no coaching, didn't address causes, etc.):____

____

Sleep Quality (Rate 5 to 1 – 5 great and 1 poor)______Do you have sleep apnea? Y / N Do you have any discomfort or pain anywhere in your body? ___

If yes, please list problem area of pain: ____

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EMP Inner Diet:

STRESS

Source of Stress	% of life stress to you
Work (job, career, etc.)	
Relationships (spouse friends, parents, etc.)	
Personal concerns (self-esteem, social status, education, etc.)	
Money (financial problems, etc.)	
Health	
Family (children)	
Time pressures (deadlines, etc.)	
Personal appearance (weight, looks, etc.)	
Personal loss (divorce, death, etc.)	
Other ______________________________	
	Total: 100%

PERSONAL DISCOMFORT

Self-Statements - **(Rate 1 to 5 with 5 is most agreeable)**

Statement					
• My eating will be much more comfortable after I am successful	1	2	3	4	5
• I accept some discomfort as part of weight loss	1	2	3	4	5
• Losing weight is worth the discomfort	1	2	3	4	5
• Discomfort means success	1	2	3	4	5
• I will succeed	1	2	3	4	5
• Controlling my eating is my responsibility	1	2	3	4	5
• Achieving my weight goal is certain	1	2	3	4	5
• Now I am in control	1	2	3	4	5

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WHY I WANT TOLOSE WEIGHT (all the reasons you can think offor your desire tolose weight)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medical Information:

Please list your medical physicians and their area ofpractice:

____

____

Do you have a pacemaker? Y / N Do you have an artificial limb? Y / N

1. Diabetes:

Diagnosed Diabetic (if no, skip to next section) Y / N

If so, are you under the care of a physician? Y / N

What type of diabetes do you have? Please check one:

- ☐ Type 1- Insulin Dependent (insulin injections only) **NE**
- ☐ Type II- Non-Insulin Dependent (diabetic pills)
- ☐ Type II-Insulin Dependent (diabetic pills & insulin) **PC**

Is your blood sugar level monitored? Y / N

If so, by whom? ____Myself ___Physician ___Other (please specify):______________________________

Do you tend to be hypoglycemic? Y / N

2. Cardiovascular Function (Heart and Vascular Conditions):

Are you currently taking medication for high blood pressure? Y / N

Has your doctor restricted your sodium/salt intake? Y / N

Are you taking cholesterol medication? Y / N

(**NE** – Not Eligible; **DL** – Doctor Letter Needed; **PC** – Proceed with Caution)

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Have you had any of the following cardiovascular conditions? Please check all that apply:

- ☐ Blood Clot **NE-DL**
- ☐ Pulmonary Embolism **NE-DL**
- ☐ Stroke or TIA **NE-DL**
- ☐ Coronary Artery Disease **NE-DL**
- ☐ Heart Valve Problem **NE-DL**
- ☐ Heart Valve Replacement **NE-DL**
- ☐ Arrhythmia **DL**
- ☐ Heart Attack
  - ☐ In the last 6 months? **NE**
  - ☐ More than 6 months ago? **DL**
- ☐ Congestive Heart Failure
- ☐ History of Congestive Heart Failure **DL**
  - ☐ Current Congestive Heart Failure **NE**
- ☐ Do you have a pacemaker? **PC-DL**

Have you ever had ANY type of cardiac/heart surgery? Y / N

If so, which type? ______________________________

Other conditions: ______________________________

If you have answered yes to any of these conditions, please give dates of occurrence:

____

3. Kidney Function:

Have you ever been diagnosed with kidney disease? Y / N **PC-DL**

Have you ever had a kidney transplant? Y / N **DL**

Are you taking any medication for this condition? Y / N

Please list medication(s) you are taking for these conditions: ______________________________

____

Have you ever had kidney stones? Y / N **PC**

Have you ever had gout? Y / N **PC**

4. Liver Function:

Do you have liver problems? Y / N **PC-DL**

If so, please specify: ______________________________

5. Colon Function:

Please check all that apply:

- ☐ Irritable Bowel Syndrome
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Ulcerative Colitis **PC**
- ☐ Crohn's Disease **PC**
- ☐ Diarrhea

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

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6. Stomach/Digestive Function:

Do you have any of the following conditions?

- ☐ Acid Reflux
- ☐ Gastric Ulcer PC-DL
- ☐ Heartburn
- ☐ History of Bariatric Surgery PC-DL
  What type of bariatric surgery? ______________________________

7. Ovarian/Breast Function:

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Fibrocystic Breasts
- ☐ Heavy Periods
- ☐ Hysterectomy
- ☐ Uterine Fibroma
- ☐ Amenorrhea
- ☐ Cancer (Uterus, Breast) DL
  Date: ____________________
- ☐ Menopause

Are you pregnant? Y / N

Are you breastfeeding? Y / N

8. Endocrine/Glandular Function:

Do you have thyroid problems? Y / N

Do you have parathyroid problems? Y / N

Do you have adrenal gland problems? Y / N

9. Neurological/Emotional Evaluation:

- ☐ Panic Attacks
- ☐ Bulimia (history of)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Schizophrenia
- ☐ Alzheimer's Disease
- ☐ Anorexia (history of) PC
- ☐ Parkinson's Disease

Please list any medications you are taking for these conditions: ______________________________

____

10. Inflammatory Conditions:

Do any of the following apply to you?

- ☐ Migraines
- ☐ Lupus
- ☐ Psoriasis
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Other Autoimmune
- ☐ Osteoarthritis
- ☐ Inflammatory Condition:

11. Cancer:

a. Do you have active cancer? Y / N
   If so, what type and where is it located? ______________________________

b. Has your cancer been in remission for less than 5 years? Y / N
   If so, what type and where is it located?

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c. Has your cancer been in remission for more than 5 years? Y / N
If so, please specify and indicate how long:

____

12. General:

Do you have any other health problems? Y / N

If so, please specify: ____

Do you take any other medications? Y / N

If so, please specify: ____

Are you currently taking any vitamins, herbs, supplements?

If so, please specify: ____

13. Allergies:

Are you gluten intolerant Y / N

Do you have Celiac's disease? Y / N

Are you allergic to:

- ☐ Peanuts
- ☐ Soy
- ☐ Dairy

Do you have any other food allergies?

If so, please list: ____

____

Eating Patterns: (please be as accurate as possible, to assist us in coaching you in the future)

Breakfast

Do you eat breakfast every morning? Yes Sometimes Never

Approximate time: ______________

Examples of breakfast foods: ____

Do you have a **snack** before lunch? Yes Sometimes Never

Approximate time: ______________

Examples of lunch foods: ____

Lunch

Do you eat lunch every day? Yes Sometimes Never

Approximate time: ______________

Examples of foods: ____

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Dinner

Do you eat dinner every day? Yes Sometimes Never

Approximate time: ________________

Examples of dinner foods: ____

Do you eat a **snack** at night? Yes Sometimes Never

Approximate time: ________________

Examples of snack foods: ____

Other:

Which do you prefer? Sweet Foods Salty Foods Fatty Foods

How many glasses of water to you drink per day?_______glasses

How many 8 oz. cups of coffee do you drink per day?______cups

Do you drink soda? Diet Reg None

Do you drink alcohol? Y / N

If so, what kind and how often: ____

The information listed above is accurate and represents my health, medical and other personal history. The EMP 180° Weight Loss program is designed to change the direction of your life, and when you follow it as directed you will lose weight and learn how to maintain your EMPowered Weight® forever. On your EMP 180° program you will learn the reasons you have added weight, and most importantly, how to address these reasons now and in the future. You will lose weight quickly without sacrificing your muscle mass and your body composition will change to one that has a higher metabolic rate. Our clients show a desire to change, they want to control the amount and frequency they are eating unhealthy foods and sugars. While on your program, EMP 180° Weight Loss will provide you food products for approximately 70% of what you eat each day which includes breakfast, lunch (you supplement with salad and/or approved Veggies) and daily snacks. We will coach you on how to prepare your dinners which consist of proper amounts of protein, approved Veggies and salad.

The amount of your financial investment in your EMP 180° Weight Loss program is based upon the number of weeks you require to reach your EMPowered Weight. The weeks will be determined by your personal body composition results and your health history.

EMP 180° Weight Loss will educate you on how to remain forever at your EMPowered Weight after you complete your weeks on the program. This is where we differ from other programs; we focus on resetting your metabolic rate to a higher number. Your metabolic rate is the rate at which your body burns energy in its resting state. You will soon learn your metabolic age which is the age that your physical body is as opposed to your chronological age. In almost all cases being overweight decreases metabolic rates,

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making metabolic age higher than actual age. EMP 180° Weight Loss is designed to reset you to your best metabolic weight (EMPowered Weight). At this number your metabolic age is the lowest possible. Not only will you look younger, you will feel younger as well.

In addition to nutritional education, we address and teach how proper exercise will help you after you reach your Empowered Weight. We also focus on the inner (psychological) reasons you have gained and cannot lose weight.

The information and education you will receive in your consultation and while on the EMP 180° Weight Loss program is not to be considered medical advice and is not intended to replace consultation with a qualified medical professional. We may or may not answer weight loss medical questions solely on our own discretion. The answers to any medical related questions should in no way be considered specific medical advice or a plan for your medical care and health management. DO NOT change or modify your medical management plan on your own without consulting your treating physician(s). We are happy to consult with your medical providers if you desire and you provide written approval.

I am ready to review my personal situations that have led to weight gain and discuss how EMP 180° Weight Loss can and will change the direction of my health and life.

Signature:____Date:___________________

If under the age of 18, client will need parental consent.

Parent/Guardian Name:_______________________________Date: _______________________

Parent/Guardian Signature: ____

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