Evolve180™
Health Profile

ABOUT YOU

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____

Occupation: _____

How did you find out about our program? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? _____ Ages? _____

EXERCISE AND EATING HABITS

Have you been on a weight loss program before? ☐Yes ☐No

If yes, which program(S) and what worked/did not work for you?

_____

_____

_____

Do you currently exercise? ☐Yes ☐No If so, what kind? _____ How often? _____

On average, how many hours of sleep do you get per night? _____

On a scale of 1 to 10, indicate what level of importance it is for you to lose weight: (circle one)

Least important 1 2 3 4 5 6 7 8 9 10 Very important

On a scale of 1 to 10, indicate your daily stress level: (circle one)

No stress 1 2 3 4 5 6 7 8 9 10 Very stressed

Do you follow any of the following diets?

☐ None ☐ Vegan ☐ Vegetarian Other: _____

Do you drink alcohol?

☐ Yes ☐ No If so, what and how often? _____

How many glasses of **water** do you drink per day? _____

How many cups of **coffee** do you drink per day? _____

Medical History

HEALTH CONTACT
Who is your primary care physician? _____

1. **HEART AND VASCULAR CONDITIONS (please check all that apply)**

☐ *None*
☐ Arrhythmia/ A-Fib
☐ Blood Clot → On medication? ☐Yes ☐No
☐ Coronary Artery Disease
☐ Heart Attack (within last 3 years)
☐ Heart Attack (prior to last 3 years)
☐ Heart Valve Problem
☐ Heart Valve Replacement
☐ Hyperkalemia (high potassium)
☐ Hypokalemia (low potassium)
☐ Hypertension (high blood pressure)
☐ Pulmonary Embolism
☐ Stroke or Transient Ischemic Attack
☐ Congestive Heart Failure
☐ Hyperlipidemia (high cholesterol)

If yes to any of the previous events, please list the dates the events occurred; if they are current, let us know:

_____

_____

Please note: if you have had a cardiac event in the past 6 months, we do require written approval from your physician prior to the beginning of your program

Have you ever had any type of heart surgery? ☐ Yes ☐ No Explain:_____

Medications (Heart and Vascular Conditions)		
Condition	*Medication*	*Dose per day*

2. **DIABETES**

Are you diabetic? (select which applies to you)

☐ *No, I am not diabetic*
☐ *No, I am not diabetic, but I have a family history of type 2 diabetes*
☐ I have been diagnosed as pre-diabetic
☐ Type 2 – Non-Insulin Dependent → Indicate Medications: _____
☐ Type 2 – Insulin Dependent →Indicate Medications: _____
☐ Type 1 → Indicate Medications: _____

Who measures your blood sugar levels? _____ How frequently? _____
How low are your severe blood sugar crashes? _____ (mg/dL)

Please note: insulin-dependent type 2 diabetes need to follow special instructions on the weight loss protocol. Your coach will explain.

3. **LIVER FUNCTION**

Have you ever had any diagnosed liver conditions? ☐ Yes ☐ No

If yes, please list: _____

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4. **KIDNEY FUNCTION** (please check all that apply)

☐ *None*

☐ Kidney Disease

☐ Kidney Transplant

☐ Kidney stones

☐ Gout If so, do you presently have gout? ☐Yes ☐No Since when? _____

If yes, what medication is prescribed? _____

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5. **COLON & DIGESTIVE FUNCTION** (please check all that apply)

☐ *None*

☐ Acid Reflux

☐ Celiac Disease

☐ Constipation

☐ Crohn's Disease

☐ Diarrhea

☐ Ulcerative Colitis

☐ Diverticulitis

☐ Gastric Ulcer

☐ Gluten Intolerance → diagnosed? ☐ Yes ☐ No

☐ Heartburn

☐ Irritable Bowel Syndrome

If yes to any of the previous conditions, please specify dates of events: _____

_____

Do you have a history of bariatric surgery? ☐ Yes ☐ No

If yes, what type and when? _____

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6. **ENDOCRINE FUNCTION**

Do you have thyroid problems? ☐ Yes ☐ No 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 diagnosed with **Metabolic Syndrome**? ☐ Yes ☐ No

Medications (Endocrine Function)		
Condition	*Medication*	*Dose per day*

7. **INFLAMMATORY AND/OR AUTOIMMUNE CONDITIONS** (please check all that apply)

☐ *None*

☐ Fibromyalgia
☐ Lupus
☐ Migraines
☐ Multiple Sclerosis
☐ Osteoarthritis
☐ Psoriasis
☐ Rheumatoid arthritis
☐ Other _____

Medications (Inflammatory / Autoimmune Conditions)		
Condition	*Medication*	*Dose per day*

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8. **OVARIAN / BREAST FUNCTION** (please check all that apply)

☐ *None*

☐ Amenorrhea (no period)
☐ Fibrocystic breasts
☐ Heavy periods
☐ Hysterectomy
☐ Irregular periods
☐ Menopause
☐ Painful periods
☐ PCOS (Polycystic Ovarian Syndrome)
☐ Uterine Fibroma

Are you taking oral contraceptive pills? ☐ Yes ☐ No (if yes, use back-up method)

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

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9. **CANCER**

Do you have cancer? ☐ Yes ☐ No

If yes, please list what type and when: _____

Do you have a history of cancer? ☐ Yes ☐ No

If yes, please list what type and when: _____

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10. **NEUROLOGICAL / EMOTIONAL FUNCTION** (please check all that apply)

☐ *None*

☐ Alzheimer's disease
☐ Anorexia (history of)
☐ Anxiety
☐ Bipolar disorder
☐ Bulimia (history of)
☐ Depression
☐ Epilepsy
☐ Panic attacks
☐ Parkinson's disease
☐ Schizophrenia
☐ Other: _____

Medications (Neurological / Emotional Function)		
Condition	*Medication*	*Dose per day*

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11. **ALLERGIES**

Do you have any food allergies? ☐ Yes ☐ No
If so, please list: _____
Do you have any food sensitivities/ intolerances? ☐ Yes ☐ No
If so, please list: _____

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12. **OTHER**

Do you have any other health concerns? ☐ Yes ☐ No
If so, please specify: _____
_____
_____
_____

_____

Client Signiture