METABOLICRX THERAPY

HEALTH RISK ANALYSIS
LIFESTYLE QUESTIONNAIRE

____/____/____
DATE OF ANALYSIS

_____
NAME

_____
ADDRESS

_____
CITY STATE ZIP

(____)_____ (____)_____
HOME PHONE WORK PHONE

____/____/____ _____
DATE OF BIRTH SEX

How to complete the questionnaire.

The information you supply in the following *Health Risk Analysis* questionnaire will be used to develop a profile of your current risk status for coronary heart disease, cancer and other lifestyle related concerns. All of the information you provide is strictly confidential. Honest and accurate answers will provide a meaningful health risk analysis report. You should read and understand each question thoroughly and then place an "X" in front of each appropriate response.

Patient: _____

Section A
Non-Controllable Risk Factors

1.0 Family history of Coronary Heart Disease occurring before 60 years old.

Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Coronary Heart Disease before the age of 60.

_____1) None
_____2) 1 person
_____3) More than 1

2.0 Family history of Coronary Heart Disease occurring after 60 years old.

Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Coronary Heart Disease after the age of 60.

_____1) None
_____2) 1 person
_____3) More than 1

3.0 Family history of Diabetes.

Indicate the number of members of your direct family (related by birth) who have been diagnosed with diabetes.

_____1) None
_____2) 1 person
_____3) More than 1

4.0 Family history of Strokes or Cerebral Vascular Disease.

Indicate the number of members of your direct family (related by birth) who have died or been diagnosed with Strokes or Cerebral Vascular Disease.

_____1) None
_____2) 1 person
_____3) More than 1

5.0 Personal history of cancer

Have you ever been diagnosed with any type of cancer?

_____1) Yes
_____2) No

6.0 Personal history of heart disease

Have you ever been diagnosed with any form of heart disease?

_____1) Yes
_____2) No

Section B
Personal Health History and Habits

7.0 Colon/Rectal Screening

If you are over the age of 40, do you have an annual colon/rectal screening?

_____1) Yes
_____2) No
_____3) Not Applicable

8.0 PAP Smear

If you are a female over the age of 18, do you have an annual PAP smear?

_____1) Yes
_____2) No
_____3) Not Applicable

9.0 Mammogram Screening

If you are a female over the age of 35, have you had a mammogram within the past 2 years?

_____1) Yes
_____2) No
_____3) Not applicable

10.0 Prostate screening

If you are a male over the age of 40, have you had a prostate screening within the past 2 years?

_____1) Yes
_____2) No
_____3) Not applicable

11.0 Routine Health Screening

How often do you see your physician for routine check-ups or health screenings?

_____1) On an annual basis
_____2) At least every 2 years
_____3) Within the past 5 years
_____4) Not within the past 5 years

12.0 Cancer Warning Signs

Indicate if you have any of the following cancer warning signs.

_____1) Change in bowel or bladder habits
_____2) Chronic indigestion or difficulty in swallowing
_____3) Thickening or lump in breast or elsewhere
_____4) Unusual bleeding or discharge, a sore that does not heal
_____5) Change in freckle or mole
_____6) Persistent cough or sore throat
_____7) Unexplained weight loss
_____8) None

How often do you consume alcohol?

_____1) Never drink
_____2) 2 days or less per week
_____3) 3 days per week
_____4) 4 or more days per week

On the days you drink, on the average how many drinks do you have?

_____1) Never drink
_____2) 1 to 2 drinks
_____3) 3 to 4 drinks
_____4) 5 or more drinks

How often do you consume caffeine in your diet including coffee, tea, cola or chocolate?

_____1) Never
_____2) Occasionally but not every day
_____3) 1 to 3 servings daily
_____4) 3 to 5 servings daily
_____5) More than 5 servings daily

Indicate which of the following best represents your current status
NOTE: Check all that apply.

_____1) Have never smoked
_____2) Quit smoking less than 5 years ago
_____3) Quit smoking more than 5 years ago
_____4) Smoke pipe or cigar
_____5) Smoke less than 1 pack of cigarettes per day
_____6) Smoke more than 1 pack of cigarettes per day

Do you use smokeless tobacco?

_____1) Yes
_____2) No

Section D
Exercise Program

18.0 Exercise Frequency

On the average, how many days per week do you exercise?

_____1) 3 or more days per week
_____2) Less than 3 days per week
_____3) No regular exercise program

19.0 Proper stretching

Do you perform stretching prior to exercise?

_____1) Always
_____2) Sometimes
_____3) Never
_____4) Currently not exercising

20.0 Warm-up and cool down

Do you warm-up and cool-down after exercising?

_____1) Always
_____2) Sometimes
_____3) Never
_____4) Currently not exercising

Section E
Nutrition Habits

21.0 [illegible]

On the average how many meals do you consume per day?
_____1) 3 meals with "healthy" snacks
_____2) 3 meals
_____3) 2 meals or less
_____4) No regular eating pattern

22.0 Consumption of grain bread products

On the average, indicate the type and amount of grain products you normally consume per day. Note: A serving is 1 slice of bread, 1/3 cup beans / peas, 1/3 cup oatmeal, rice or other grain products. Choose the response that best describes your eating habits.

_____1) Whole grains at least 6 or more servings per day
_____2) Whole grains 6 servings or fewer servings per day
_____3) Refined grains such as white bread/rolls/processed flour at least 6 or more servings a day
_____4) Refined grains such as white bread/rolls/processed flour 5 or less servings per day
_____5) Rarely consume grain products

25.0 Consumption of vegetables

On the average, how many servings of vegetables do you consume per day? Note: A serving is approximately 1 cup of raw or 1/2 cup of cooked.

_____1) At least 3 to 5 servings per day
_____2) Less than 3 servings per day
_____3) Rarely consume vegetables

24.0 Consumption of fruits

On the average, how many servings of fruit do you consume per day? Note: A serving is approximately 1 piece of fruit.

_____1) At least 2 to 4 servings per day
_____2) Less than 2 servings
_____3) Rarely consume fruit

25.0 Daily consumption of dairy products

On the average, how many servings of dairy products do you consume per day? Note: A serving is approximately 1 cup of milk or 1 oz. of cheese.

_____1) At least 2 servings per day
_____2) Less than 2 servings
_____3) Rarely consume dairy products

26.0 Type of Dairy products

Indicate the type of dairy products you consume.

_____1) Nonfat selections only
_____2) Both low fat and nonfat about the same
_____3) Low fat only
_____4) Usually high fat selections
_____5) Do not consume dairy products

27.0 Daily consumption of meat/protein products

Indicate the type of meat you normally consume. Note: Choose the response that best describes your eating habits

_____1) Do not consume meat or meat products
_____2) Consume less than 6 oz. of low fat poultry or fish per day
_____3) Consume more than 6 oz. of low fat poultry or fish per day
_____4) Consume less than 6 oz. of high fat red meat per day
_____5) Consume more than 6 oz. of high fat red meat per day

28.0 Consumption of fats, dressings and spreads

Indicate the type and number of servings of fat, dressings and spreads you consume each day. Note: High fat examples include butter, lard, and margarine, low fat examples include non-fat low-fat salad dressing, mayonnaise and cheese. Choose the response that best describes your eating habits. A serving is approximately 1 tablespoon.

_____1) Use low fat selections sparingly (less than 3 per day)
_____2) Use low fat selections frequently (3 or more per day)
_____3) Use both low fat and high fat about the same sparingly (3 or less)
_____4) Use high fat selections sparingly (less than 3 per day)
_____5) Use high fat selections (more than 3 per day)

On the average, how many glasses of water do you consume per day? Note: A serving is one 8-oz. glass of water only; do not include coffee, soda or other beverages.

_____1) At least 8 glasses per day
_____2) About 4 to 8 glasses per day
_____3) Less than 4 glasses per day
_____4) Seldom consume water

[illegible] convenience and snack food consumption

On the average how many times per day do you eat convenience foods or forms of fast food?

_____1) Never
_____2) Less than 1 time per day
_____3) More than 1 time per day

Section F
Personal Health

31.0 Dental Check-up

Do you have an annual check-up with your Dentist?

_____1) Yes
_____2) No

32.0 Oral Health

Do you have any abnormal bleeding in your gums or around your teeth?

_____1) Yes
_____2) No

33.0 Eye Examination

How often do you see an eye specialist?

_____1) Once per year
_____2) Once every two years
_____3) Not within the last 2 years
_____4) No regular exams

34.0 Living Environment

Do you live or work in an environment, which you consider to expose you to pollution, either air, water or from your food?

_____1) Yes
_____2) No

35.0 Smoke Detector

Do you have at least one (1) working smoke detector for each floor of your home or apartment, which you check on a monthly basis?

_____1) Yes
_____2) No

36.0 Seat Belt Use

How often do you use your seat belt when either operating a motor vehicle or riding as a passenger?

_____1) Always
_____2) Sometimes
_____3) Never

37.0 Automobile Mileage

How many miles per month do you drive an automobile or ride as a passenger?

_____1) Less than 1000
_____2) Between 1001 to 1499
_____3) More than 1500 per month

38.0 Automobile Maintenance

If you own an automobile, do you have regular maintenance performed such as checking the tires, oil etc.?

_____1) Not applicable
_____2) Yes
_____3) No

39.0 Fire Protection

Do you have a working fire extinguisher in your home?

_____1) Yes
_____2) No

Section H
Osteoporosis

48.0 Osteoporosis

Have you ever been diagnosed with or indicated that you were at risk for Osteoporosis?

_____1) Yes
_____2) No
_____3) Not applicable

MetabolicRx Therapy
HEALTH RISK ANALYSIS

Section G
Lab Results

*** ***DO NOT COMPLETE THIS SECTION*** ***

BODY COMPOSITION: _____

CHOLESTEROL: _____ TRIGLYCERIDES: _____

HDL: _____ SYSTOLIC BP: _____

DIASTOLIC BP: _____ HEART RATE: _____

FASTING GLUCOSE: _____

Facilitator notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date: _____

Disclaimer

The MetabolicRx Therapy™ Program provides state-of-the-art analysis including: Health Risk Appraisal, Body Composition Analysis and Individualized Nutrition and Exercise Recommendations.

The information requested on this questionnaire is important to develop your customized program. All information and results are CONFIDENTIAL.

Today's Date ___/___/___

Last Name_____ First_____ MI___

Address_____

City_____ State_____ Zip_____

Social Security Number_____-_____-_____

Phone Number H (_____)_____-_____ W (_____) _____-_____

Physician's Name_____

Physician's Number_____

May we send your physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency:

Name_____

Relationship_____ Phone (_____)_____-_____

Your Date of Birth _____/_____/_____ Age_____ Sex M F (Circle one)
Month Date Year

Disclaimer

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program. I take full responsibility for my participation in any of these programs for any claims for injuries or illness that may result from my participation in any of their programs.

_____ _____
Signature Date

_____ _____
Witness Date

METABOLIC Rx THERAPY

MEDICAL HISTORY

Includes American College of Sports Medicine Coronary Risk Factors

Do you now, or have you had in the past:	**NO**	**YES**
1) History of heart problems, recurring chest pain, heart murmur, or stroke	___	___
2) Diagnosis of Hypertension or take medicine for same	___	___
3) Diabetes Mellitus	___	___
4) Asthma, breathing or lung problems	___	___
5) Cancer (other than skin)	___	___
6) Seizures, seizure medication, neurological problems or severe dizziness	___	___
7) Gallbladder disease or intestinal problems	___	___
8) Back problem, joint or muscle disorder still affecting you	___	___
9) Recent surgery (last 12 months)	___	___
10) Hernia or any condition that may be aggravated by lifting weights	___	___
11) Physician's advice not to exercise	___	___
WOMEN ONLY:		
12) Are you pregnant, lactating or anticipating becoming pregnant?	___	___

If your answer is YES to any question above, give *brief* explanation:_____

_____

13) History of total Cholesterol greater than 240 mg/dl	___	___
14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55	___	___
15) History of cigarette smoking	___	___
16) Do you take vitamins?	___	___
17) Are you allergic to soy?	___	___
18) Are you allergic to lactose/dairy products?	___	___
19) Are you taking any medications?	___	___

If so, what? _____

_____

_____

SIGNATURE

AUTHORIZATION FOR RELEASE OF RECORDS

TO:

This authorization for disclosure of medical information is submitted to you in accordance with the terms of the Confidentiality of Medical Information Act of 1981, California Civil Code, Section 58, et. seq. This Authorization complies with the requirements of HIPAA Privacy Rule except when other applicable law imposes additional or more stringent authorization requirements.

This document authorizes you to allow the undersigned patient and/or _____**(clinic name)**their agents, designees or representatives bearing this authorization to inspect, examine, review, and/or copy of any and all medical and/or dental records, original x-ray films, x-ray reports, billing records and records of every description, whether as an emergency room patient, in-patient or out-patient, and pertaining to any and all care, treatment, examination, consultation, diagnostic testing and/or hospitalization, and any other medical services rendered the patient below:

Name of Patient	Date of Birth	Social Security No.	Medical Record No.

I, _____ specifically authorize release of the above referenced records.

This authorization shall become effective immediately and shall remain in effect until _____. If no date is given, authorization will expire one year from the date of signature. (Date)

Information disclosed pursuant to this authorization could be re-disclosed by the recipient, and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I have a right to revoke this authorization request at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to _____**(clinic name)**. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.

The undersigned acknowledges that he/she has the right to receive a copy of this authorization. **Photocopies of this form may be made and used as originals.**

DATE: _____

_____
[Patient signature]

Evidence Code Section 1158: Failure to make such records available during business hours, within five days after presentation of this written authorization, may subject the person or entity having custody and control of the records to costs and attorney's fees incurred in enforcing the provisions of this section.

Rev. 12/03