Find the Cause of Your Weight Problem

Take the Quiz to Find out What Diet you Should be On!

At this point, you need to determine which body type you have. Knowing this information is the first key step in making stubborn weight loss a thing of the past. It will reveal which diet to be on – the diet that will help heal the sluggish gland that is making it a tough task or even an impossibility to lose weight. It is totally possible to attain your desired weight and to keep the extra weight off for the rest of your life. You are on your way to looking and feeling even better than you do now! And if you don't like the way you look and feel right now, then you're going to start to change that point of view here and now!

The Body Shape Quiz

DIRECTIONS: Circle <u>one</u> letter (A, B, C, or D) in each question. If there is more than one symptom that you are experiencing within a question, circle the one that is most prominent.

1. Do you...		
	A. crave sweets, breads and pasta?	Thyroid
	B. crave salt, (pretzels, cheese or chips)?	Adrenal
	C. crave pickles and deep fried foods?	Liver
	D. crave creamy spicy hot foods?	Ovary
2. Are you...		
	A. often depressed or feeling hopeless?	Thyroid
	B. a worrier or often anxious?	Adrenal
	C. easily angered, moody in the morning?	Liver
	D. moody or irritable at certain times of the month?	Ovary
3. Do you...		
	A. feel better on fruits and berries?	Thyroid
	B. need coffee or stimulants to wake up?	Adrenal

	C. desire fatty foods, experience a tight feeling over your right, lower stomach or rib cage?	Liver
	D. experience constipation during menstruation?	Ovary
4. Do you have...		
	A. brittle nails with vertical ridges?	Thyroid
	B. brittle nails with no vertical ridges?	Adrenal
	C. pain/tightness in right shoulder area?	Liver
	D. pain in right or left lower back/hip area?	Ovary
5. Do you have...		
	A. a weight problem more evenly distributed?	Thyroid
	B. a larger abdomen with thinner legs and arms?	Adrenal
	C. a protruding abdomen (pot belly)?	Liver
	D. excess fat in lower thighs and hips?	Ovary
6. Do you have...		
	A. dry skin?	Thyroid
	B. swollen ankles; socks leave creases on ankles?	Adrenal
	C. bloating after eating?	Liver
	D. menstrual cyclic hair loss?	Ovary
7. Do you have...		
	A. big or thick ankles?	Thyroid
	B. a round face?	Adrenal
	C. finger joints that become swollen or painful in the morning?	Liver
	D. hot flashes or history of bad menstruation?	Ovary
8. Do you have...		
	A. outer eyebrows losing hair?	Thyroid
	B. dizziness when sitting up?	Adrenal
	C. hot feet or swollen feet?	Liver
	D. menstrual cyclic brain fog?	Ovary
9. Do you have...		
	A. internal body always cold?	Thyroid
	B. pain & inflammation in body?	Adrenal
	C. headaches or head feels heavy in morning?	Liver
	D. excessive menstrual bleeding?	Ovary

10. Do you have...	A. puffiness around eye?	Thyroid
	B. unusual feeling of "out of breath" while climbing stairs?	Adrenal
	C. brown/red spots on skin?	Liver
	D. low sex drive?	Ovary
11. Do you...	A. have excessive skin sagging under arms?	Thyroid
	B. have water retention yet feel dehydrated?	Adrenal
	C. get up 1-2 hours before alarm clock?	Liver
	D. have weight gain around menstrual period?	Ovary
12. Do you...	A. have dry hair and hair loss?	Thyroid
	B. wake up in the middle of the night (2 - 4 a.m.)?	Adrenal
	C. have a deep crease down center of tongue?	Liver
	D. waist and upper body is thinner than lower body?	Ovary
13. Do you have...	A. a thick tongue?	Thyroid
	B. dark circles under eyes?	Adrenal
	C. cracks on your heels?	Liver
	D. smaller breasts?	Ovary
14. Do you...	A. get tired easily from exercise / is your body tired all the time?	Thyroid
	B. need a nap around 3:00 in the afternoon?	Adrenal
	C. feel you're not a morning person, but a night person?	Liver
	D. have history of ovarian cysts?	Ovary

Count up the total of each:

Total Thyroid _____
Total Adrenal _____
Total Liver _____
Total Ovary _____

The body type with the highest number is your body type.

Weight Loss Questionnaire

1. What's your goal with weight? How much do you need to lose?

   _____

2. What would your life be like if you were able to be at your ideal weight and fit into your clothes?

   _____

   _____

3. When were you last at your ideal weight?

   _____

4. When did you start to gain weight?

   _____

5. Where do you tend to hold the weight?

   _____

6. What do you hate most about having a weight issue?

   _____

7. Is there a specific weight or size that you must NOT exceed? _____
8. What would happen if you did exceed that weight, how would that impact your life?

   _____

   _____

9. Tell me about your overall will power and discipline?

   _____

   _____

10. On a scale of 1 to 10 how commited are you to losing weight? 1 2 3 4 5 6 7 8 9 10
11. How has this weight affected your relationships?

    _____

12. Do you have any relatives who have arthritis, diabetes, heart disease or cancer?

    _____

13. Do you crave caffeine, chocolate, fatty food, sweet food or salty food? Circle the ones you crave.
14. Do you crave bread, bagels or pasta? Circle the ones you crave.
15. Have you ever been on birth control pills? Yes/No How long? _____
16. Are you taking any antidepressants? Which one?_____
17. What do you typically eat for breakfast?

    _____

18. What do you typically eat for lunch?

    _____

    _____

19. What do you typically eat for dinner?

    _____

    _____

20. What do you typically eat for snacks?

    _____

21. What do you drink?

    _____

    _____

Weight Loss Evaluation

1. Tell me about your weight-loss history. When did you first start to gain weight? What worked to lose weight? What didn't work? How fast did the weight come back?

_____

_____

2. How has being overweight served you? How has it held you back?

_____

3. What are the consequences to your health if you continue to be overweight?

_____

4. How will you feel about yourself 10 years from now if things are the same... or worse?

_____

5. In what areas do you find being overweight a problem for you now?

_____

6. What are you eating that might be causing your weight gain?

_____

7. What would you say are your top 3 problems to overcome to permanently lose your excess weight?

_____

8. How valuable would being in shape be to you?

_____

9. In what ways has being overweight hurt the quality of your life?

_____

10. What is being overweight costing you in time, energy or stress?

_____

11. How much money is being overweight costing you?

_____

12. How have your relationships been hurt by being overweight?

_____

13. What are a few of the enjoyments you're missing out on by being overweight?

_____

14. How would you feel about yourself if you became free from being overweight for good in the next 2-3 months?

_____

15. What would you do that you can't do now?

_____

16. What would your life be like if you solved your weight issue for good?

_____

_____

17. What's most important to you about being free from being overweight?

_____

18. What do you think you need to do to lose weight in a natural and permanent way?

_____

19. In what ways will your life be different after we've helped you lose weight permanently?

_____

PATIENT'S NAME: ..... DATE: .....

HGT[INCHES]: .....

WGT[LB]: .....

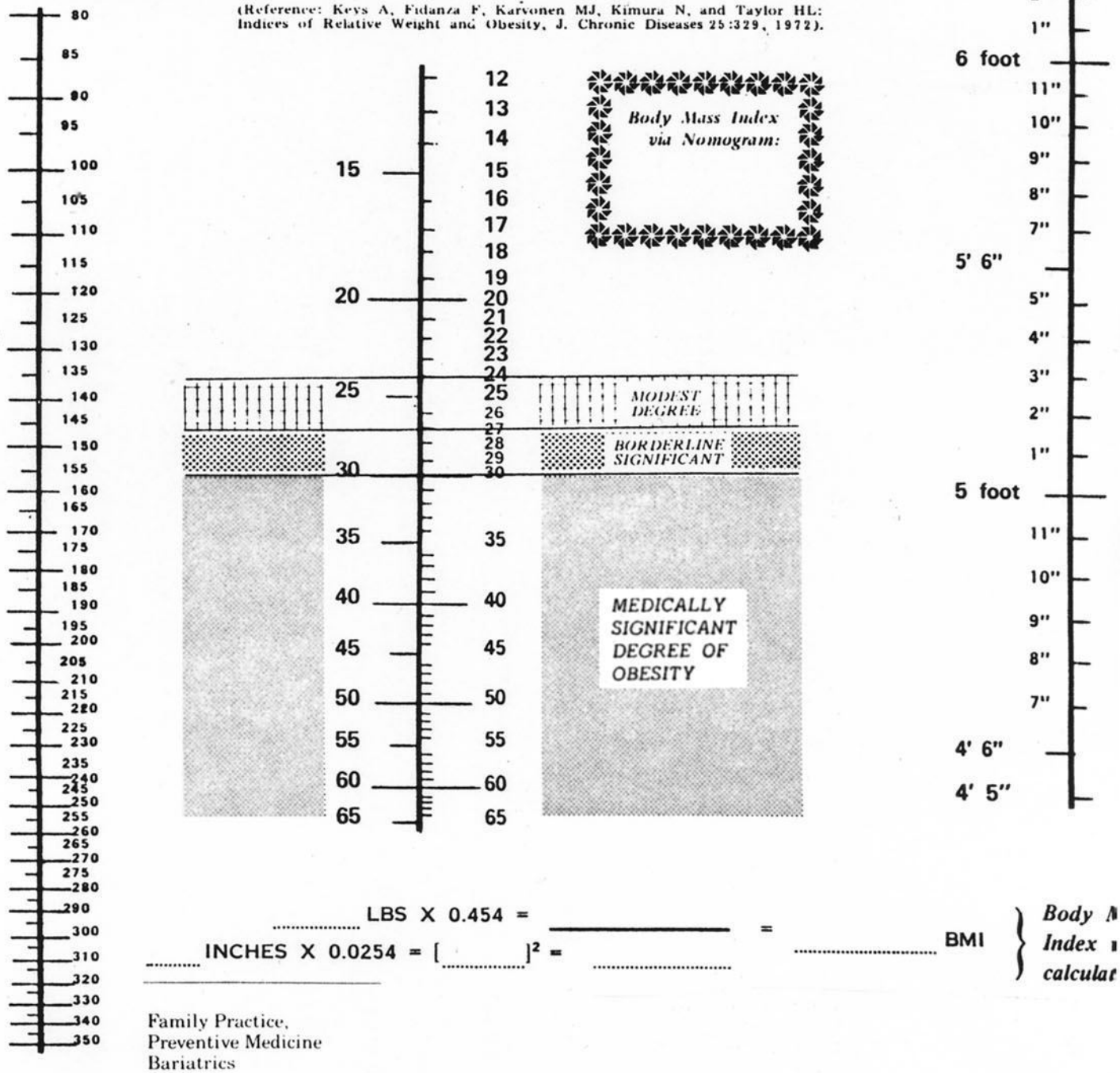
NOMOGRAM for Body Mass Index

Weight (in pounds)

Height (in ft. & in.)

BODY MASS INDEX = Weight (kg) ÷ Height (meters)^2

(Reference: Keys A, Fidanza F, Karvonen MJ, Kimura N, and Taylor HL: Indices of Relative Weight and Obesity, J. Chronic Diseases 25:329, 1972).



..... LBS X 0.454 = _____ = ... BMI

..... INCHES X 0.0254 = [.....]^2 = ...

Body Mass Index is calculat

Family Practice,
Preventive Medicine
Bariatrics

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal? _____ **years**

Since menopause, do you ever have uterine bleeding?	Yes	No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Lipo-Light and Whole Body Vibration Survey

Please circle the number if you have any of the following:

1. Pregnancy
2. Diabetes with complictions eg. neuropathy or retinal damage
3. Recent surgery-open cuts or postopertive wounds
4. Active cancer or tumor, or cancer in remission
5. Epilepsy
6. Migraines
7. Herniated discs
8. Spondylolisthesis, spondylolysis
9. Recent hip, knee or other joint replacements
10. Recently placed IUD's
11. Metal pins or plates
12. HIV/Aids
13. Hepatitis C/D
14. Schizophrenia, manic depression
15. Pacemaker
16. Auto-immune diseases
17. Severe heart and vascular diseases
18. Thrombotic conditions
19. Metabolic disorders
20. Kidney or Liver disease
21. Lymphatic system dysfunction
22. Hypertension
22. I don’t have any of the above

_____ _____

Patient’s Signature Date

Dr. Raphael
959 Mountain View Drive.
Lafayette, Ca. 94549

Office Policy

Congratulations on choosing Dr. Raphael to support you in rejuvenating and maintaining your health.

1. This is primarily a cash based office. Payment is due in advance of each visit.
2. If you miss an appointment and do not notify Dr. Raphael at least 48 hours in advance you will be charged for the missed appointment.
3. All missed appointments need to be made up. If you need to change or reschedule an appointment, please tell Dr. Raphael at least 48 hours in advance.
4. If you have been involved in an auto accident, a personal injury or work related injury and you miss an appointment and do not notify Dr. Rettner at least 48 hours in advance you will be charged for the missed appointment. We cannot ethically charge your insurance company for your missed appointment.
5. I agree not to discharge myself from care without a re-examination and speaking personally with Dr. Raphael.

I have read and understand the office policy of Dr. Raphael
I acknowledge and accept my responsibilities and agree to comply with these standards

_____ _____

Patient's Signature Date