



Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Age: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ BMI: \_\_\_\_\_ Fat %: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Sex: M F Marital Status: M S D W  
How did you hear about the ITG Diet? \_\_\_\_\_  
Do you have children? Yes No Ages of children: \_\_\_\_\_

### Your Goals/Challenges/Support

Why do you want to lose weight? \_\_\_\_\_

What have been your challenges losing weight in the past? \_\_\_\_\_  
\_\_\_\_\_

What other diets have you been on before: \_\_\_\_\_

Do you have family or a friends support to go on a plan? Yes No

Who and relationship: \_\_\_\_\_

Hours sleeping: \_\_\_\_\_ Hours working: \_\_\_\_\_ Exercise program: Yes No

Exercise Frequency: Daily 1-2 days/wk 3-5 days/wk 6-7days/wk Never

Current level of stress, scale of 1-10 (10 being High): \_\_\_\_\_

How motivated are you to improve overall health and lose weight, scale of 1-10? \_\_\_\_\_

What are your goals? Goal Weight \_\_\_\_\_ Goal BMI \_\_\_\_\_ Goal Fat % \_\_\_\_\_

Do you have a partner or friend who would like to start the plan with you? Yes No

If yes, who: \_\_\_\_\_



Medical Information (If no on any of these issues check NA and skip to next section)

<b>Diabetes/Hypoglycemic</b>			NA
Type 1	Insulin dependent (injections only)		
Type 2	Could be insulin and/or oral medication		
Are you under the care of a physician?    Yes        No			
If so, Name of the Physician: _____			
Phone: _____			
Are you Hypoglycemic:    Yes        No			
Diabetic medications:			
Medication	Dosage	X/Day	Notes

<b>Cardiovascular</b>			NA
Arrhythmia	Heart Valve Problem		
Blood Clots	High Cholesterol		
Congestive Heart Failure	Hypertension (High Blood Pressure)		
Heart Attack	Stroke or TIA		
Heart Surgery			
If any of the events above, please give more details and date of each event.			
_____			
_____			
_____			
Medications for any of the above:			
Medication	Dosage	X/Day	Notes





**Digestive Functions**

NA

Do you have any of the following?

- Acid Reflex
- Gastric Ulcer
- Heartburn

- Bariatric Surgery
- Lap Band Surgery
- Other

If any of the events above, please give more details and date of each event.

---



---



---

Medications for any of the above:

Medication	Dosage	X/Day	Notes

**Inflammatory Conditions**

NA

Do you have any of the following?

- Arthritis
- Chronic Fatigue
- Gout
- Fibromyalgia
- Lupus

- Migraines
- Psoriasis
- Other

If any of the events above, please give more details and date of each event.

---



---



---

Medications for any of the above:

Medication	Dosage	X/Day	Notes



**Cancer** NA

Do you have cancer?                      Yes              No  
 Have you ever had cancer?              Yes              No  
 Are you in remission?                      Yes              No

If you have had cancer please give details and dates below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications

Medication	Dosage	X/Day	Notes

**Emotional Evaluation** NA

Do you have any of the following?

Anorexia    Drug Addiction  
 Anxiety    Panic Attacks  
 Bipolar Disorder                                    Schizophrenia  
 Bulimia    Other  
 Depression

If any of the events above, please give more details and date of each event.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications for any of the above:

Medication	Dosage	X/Day	Notes



**Pulmonary Issues** NA

Do you have any of the following?

Asthma	Emphysema	Other
COPD	Cystic Fibrosis	
Chronic Bronchitis		

If any of the events above, please give more details and date of each event.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications for any of the above:

Medication	Dosage	X/Day	Notes

**Other Conditions** NA

Do you have any of the following?

Alzheimer's	Hypothyroidism	Other
Parkinson's	Seizures	
Multiple Sclerosis		

If any of the events above, please give more details and date of each event.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications for any of the above:

Medication	Dosage	X/Day	Notes



**For Women Only**

NA

Do you have any of the following?

Fibrocystic Disease  
Hysterectomy  
Irregular Periods

Menopause  
Polycystic Ovary Syndrome (PCOS)  
Uterine Fibroids

Date of your last Menstrual Cycle \_\_\_\_\_

Are you Pregnant? Yes No      Are you breastfeeding? Yes No

If any of the events above, please give more details and date of each event.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications for any of the above:

Medication	Dosage	X/Day	Notes

**Please note** - Rapid weight loss may cause an increase in the level of estrogen in the bloodstream. This in turn may possibly affect menstrual cycle regularity, change PMS symptoms, and or increase fertility. Please contact your OB-GYN if you have any concerns or questions. It is recommended when on the plan to use an alternative birth control method if on oral contraceptives.

**General Questions**

Do you have any allergies? Yes No Explain if yes:

\_\_\_\_\_  
\_\_\_\_\_

Are you a Vegetarian? Yes No      Are you a Vegan? Yes No

How many glasses of water do you drink per day? \_\_\_\_\_

How many cups of coffee do you drink per day? \_\_\_\_\_

Do you drink alcohol? Yes No If yes, what do you normally drink and how often?

\_\_\_\_\_



Please explain what you normally eat in a day:

Breakfast: What time to do you eat Breakfast? \_\_\_\_\_

Lunch: What time to do you eat Lunch? \_\_\_\_\_

Dinner: What time to do you eat Dinner? \_\_\_\_\_

Snack: What time to do you eat Snacks? \_\_\_\_\_

What supplements do you currently take? Please list below:

Supplement	Dosage	X/Day	Notes

Please list your Primary Care Physician and any other physicians that you see on a regular basis:

Physician	Specialty	City	Phone number

Any other comments about your overall health? List below:

---



---



---



---





**Informed Consent for ITG Diet Weight Control Plan**

I affirm that the information on this Health Status Intake Form is complete and accurate and I have disclosed any medical conditions that may be contraindications to go on the ITG Diet weight loss plan. \_\_\_\_\_ (please initial here)

I understand that I must take the supplements that are provided by ITG while I am on the ITG Diet weight loss plan. \_\_\_\_\_ (please initial here)

Consent to participate:

I hereby consent to act as a participant in a weight control plan involving the use of protein and other supplements. I understand that various employees may provide this to me.

If I have any questions about this or need further explanations, I understand that I should speak with my medical provider before starting any weight loss program.

I have been informed that the possible benefit and value of this treatment is not guaranteed. I understand that there are many alternative treatments or procedures that are appropriate and available that might be beneficial to me. Some of those alternatives or choices include but may not be limited to:

- 1. No treatment at all.
- 2. Conservative lifestyle changes.
- 3. Drugs.
- 4. Surgery.
- 5. Watch and wait, while reporting my condition to a physician.

I understand that I have the right not to participate in this plan or to discontinue it after I have begun, for any reason whatsoever. I understand that I have the right to ask questions and to know the purpose and objectives of my weight loss plan.

Having read this page, I hereby consent to this plan. I have had adequate time to ask any questions and understand the answers provided. At this time I have no other questions, but I am aware that any future questions may be posed and will be responded to in a timely fashion.

Dieter Name \_\_\_\_\_

Dieter Signature \_\_\_\_\_

Date \_\_\_\_\_

Coach Signature \_\_\_\_\_

Date \_\_\_\_\_