

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 one 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

WEIGHT

Name: _____ Date: _____

1. Where do you tend to hold the weight?

2. Have you ever started a program and didn't stick with it? _____
3. Tell me about your overall will power and discipline?

4. Has weight loss become difficult despite efforts to diet and exercise? Tell me about it?

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

6. Are CRAVINGS to sweets, breads, chocolate and salty foods interfering with your weight? _____ In what way?

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

8. Did you find that you started gaining weight after MENOPAUSE or pregnancy or something else? _____ Tell me about this?

9. How has this weight affected your relationships?

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

11. What would your life be like if you were able be at your ideal weight and fit in your clothes? _____

12. And if you lost the weight, how would this affect your self-esteem?

13. How would it influence your relationships? _____

Weight Loss Difficulty Questionnaire

1. What do you typically eat for breakfast?
2. What do you typically eat for lunch?
3. What do you typically eat for dinner?
4. What do you typically eat for snacks?
5. What do you drink?
6. When were you last at your ideal weight?
7. When did you start to gain weight?
8. Have you ever been on birth control pills? How long?
9. Are you on hormone replacement therapy?
10. Did your mother take DES when she was pregnant with you?
11. Have you ever been on a low calorie diet?
12. How many hours sleep do you get per night?
13. Have you tried many diet programs? Which ones?
14. Did you lose more weight on a high protein or high vegetable diet?
15. Are your parents overweight?
16. Are your grandparents overweight?
17. Does low thyroid run in your family?
18. Do you eat organic foods now?
19. How long have you eaten organic?
20. What is your age?
21. Do you have any children? How many?
22. Have you ever had mono or EBV?
23. Have you ever tried the Atkins diet?
 - a. Did you lose weight on the Atkins diet?
 - b. Did the weight loss stop after several weeks?
24. Do you have cravings? For what?
25. What would have to happen for you to lose weight?
26. Do you lack will power?
27. Do you think you can be helped with weight loss?

The Most Commonly Reactive Foods

Please circle any of the following foods that you eat at least once a month:

<ol style="list-style-type: none">1. Wheat2. Dairy3. Eggplant4. Green and red bell peppers5. Tomatoes6. Potatoes7. Cayenne8. Paprika9. Eggs10. Corn11. Soy12. Peanuts13. Shellfish-shrimp, clams, oysters, crab and lobster14. Citrus fruit-orange, lemon, lime, grapefruit15. Chocolate16. Coffee17. Gluten-wheat, rye, barley, oats, kamut and triticale.18. Yeast (found in bread)19. Aspartame20. Beer and Wine21. Cocktail Mixes, such as margaritas22. Additives and preservatives23. M.S.G. (Monosodium Glutamate)-found in Chinese food	<ol style="list-style-type: none">II. Occasionally Reactive Foods24. Bacon and other pork products25. Beef26. Chicken27. Black Pepper28. Cinnamon29. Cloves, curry and turmeric30. Mustard31. Vinegar32. Grapes & raisins33. Bananas34. Berries especially strawberries35. Cherries36. Melon37. Pineapple38. Plums39. Celery40. Onions41. Peas42. Mushrooms43. Coconut44. Cashews45. Quinoa46. Kidney beans, pinto beans Black beans
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PATIENT'S NAME:

DATE:

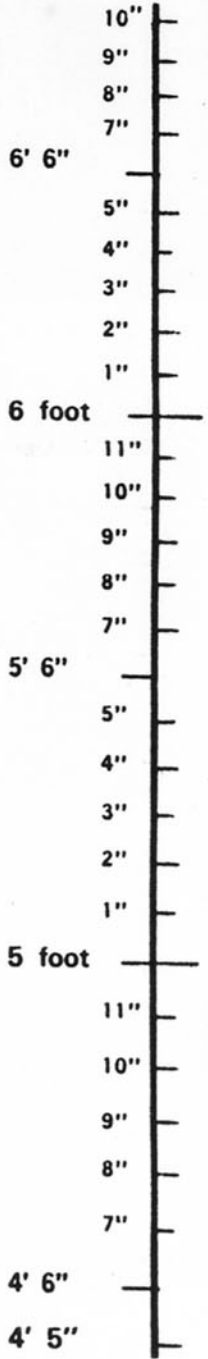
Height

HGT[INCHES]:

(In ft. & in.)

WGT[LB]:

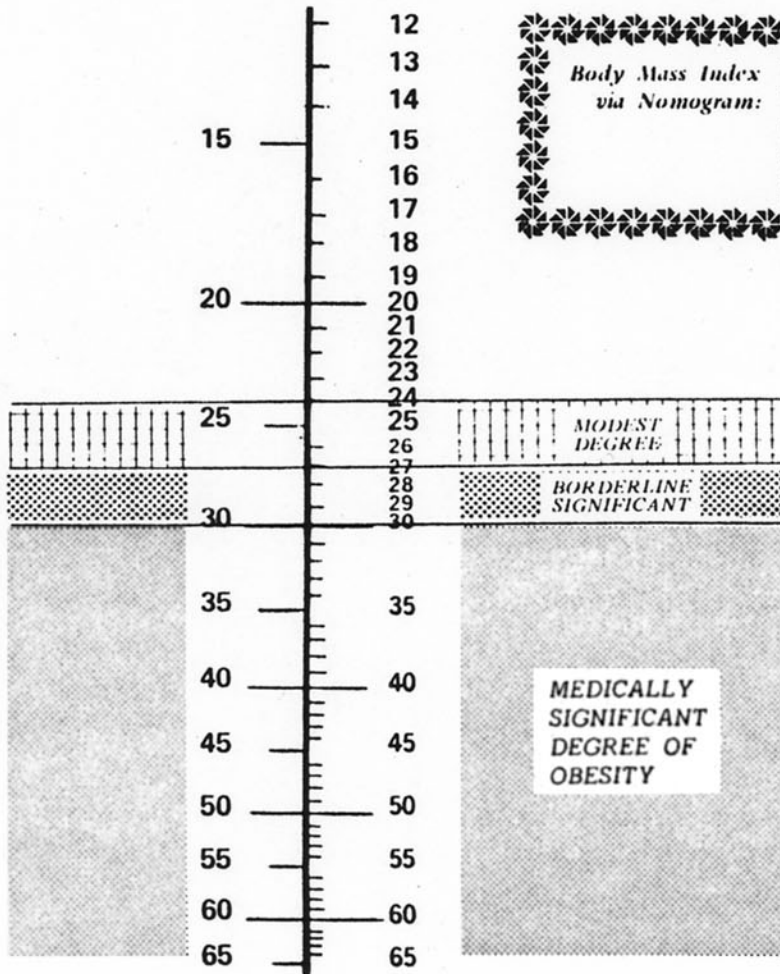
NOMOGRAM for Body Mass Index



Weight
(In pounds)

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 } *Body Mass Index calculated*

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

Family Practice,
Preventive Medicine
Bariatrics

Metabolic Assessment Form

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

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

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

Please circle the appropriate number “0 - 3” 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 relief 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 of “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			
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 foods found in stools	0	1	2 3
Category III			
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2 3
Do you frequently use antacids?	0	1	2 3
Feeling hungry an hour or two after eating	0	1	2 3
Heartburn when lying down or bending forward	0	1	2 3
Temporary relief from antacids, food, milk, 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 IV			
Roughage and fiber cause constipation	0	1	2 3
Indigestion and fullness lasts 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
Nausea and/or vomiting	0	1	2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	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

Category V			
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
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 VI			
Crave sweets during the day	0	1	2 3
Irritable if meals are missed	0	1	2 3
Depend on coffee to keep yourself going or started .	0	1	2 3
Get lightheaded if meals are missed	0	1	2 3
Eating relieves fatigue	0	1	2 3
Feel shaky, jittery, 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 VII			
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 & appetite	0	1	2 3
Difficulty losing weight	0	1	2 3
Category VIII			
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 IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X				
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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XI				
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
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain 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
Decrease in 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 XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
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

How many alcohol beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

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

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

Do you smoke? _____ If yes, how many times a day: _____

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

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

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