DuPage Healthcare,Ltd.
LIVING WELL STARTS HERE

Metabolic & Weight Loss Paperwork

Welcome to DuPage Healthcare. We are pleased you have chosen us to be your partner in healthcare and are confident that you have made the right decision.

DuPage Healthcare has focused on health and healing in our community for nearly 23 years. As we innovate and grow, we keep one thing at the forefront of all we do, and that is what is best for our patient – what is best for you.

One thing we know is essential in being partners in your health is communication. This paperwork was developed to help Dr. Pepping to understand your condition and especially how it may be affecting your quality of life. We ask that you answer it as thoroughly and honestly as possible.

Our office is successful because we listen to our patients and create programs that are specifically made for them. You may find our paperwork lengthy, but each question brings us closer to the answers you are looking for and the quality clinical care you need.

YOUR APPOINTMENT DAY-

We require that your paperwork is completed before your appointment.

Because Dr. Pepping always runs on time, we ask that you do the same.

We take our work very seriously and are honored that you trust us with your care.

Sincerely,

DuPage Healthcare Staff

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NEW PATIENT DEMOGRAPHICS

Whom may we thank for referring you to our clinic?

_____

Today's Date: _____

PATIENT'S DEMOGRAPHICS

Name:_____Birth Date _____ Age: _____

☐ Male ☐ Female

Address:_____City:_____State:_____Zip: _____

Employer:_____Occupation: _____

Home Phone:_____Work:_____Cell:_____- _____

Last 4 digits will be used for your check in code

Marital Status: ☐ Single ☐ Married ☐ Widowed

E-mail Address:_____@ _____

Email is used to remind you of appointments and to share relevant health topics

☐ Gmail ☐ Comcast ☐ yahoo ☐ sbcglobal ☐ AOL

OTHER CONTACT INFORMATION

Spouse's Name_____Phone: _____

Emergency Contact Name:_____Relationship:_____

Emergency ContactNumber: _____

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blueprint nutrition

Weight History

Depending on the nature of your condition, some of these questions may not apply to you.

Name:_____ Date: _____

GENERAL

Weight:_____Goal Weight:_____

How long have you been on your weight loss journey? _____

Which diet(s) or changes in eating habits have you tried before? _____

Why do you think it didn't work for you? _____

Have you been looking into other programs for your concerns?____No___If Yes, which ones? _____

What price range are you looking to stay in? $_____

Do you Exercise?_____No_____If Yes, how often?_____For how long? _____

What is the hardest part for you when dieting or changing eating habits? _____

What do you think is the cause of your weight gain or food reactions? _____

MEDICAL

Please mark below the symptoms you are experiencing

☐ Belly fat	☐ Digestive issues	☐ Dry skin	☐ Can't fall asleep	☐ Moody
☐ Sugar cravings	☐ Feel horrible	☐ Skin issues	☐ Restless sleep	☐ Low libido
☐ Brain fog	☐ Achy muscles	☐ Always hungry	☐ Don't sleep well	☐ Poor concentration
☐ Joint pain	☐ Fatigue	☐ Depression	☐ High Cholesterol	☐ Eat large portions
☐ Sinus infections	☐ Headaches	☐ Crave fat foods	☐ High blood pressure	

In the last 6 months, have you had any stiffness, pain, or arthritic problems in any areas below?

☐ *Neck*	☐ *Middle back*	☐ *Lower back*	☐ *Hips*	☐ *Migraines*	☐ *Knees*	☐ *Foot/Ankle*
☐ *Shoulder*	☐ *Arms*	☐ *Hands/Wrist*	☐ *Legs*	☐ *Numbness*	☐ *Tingling*	

For these questions it is important that we understand your complete health history.
Please try to be as thorough as possible.

List all professionals you see for your health. If you cannot remember medication names, list why you are taking them.

1. _____ For: _____
   Medications: _____
2. _____ For: _____
   Medications: _____
3. _____ For: _____
   Medications: _____

Please list other conditions, diseases, or surgeries: _____

_____

EATING & OTHER HABITS

Breakfast

Do you have breakfast every morning? ☐ Always ☐ Sometimes ☐ Never

Examples: _____

Do you have a snack before lunch? ☐ Always ☐ Sometimes ☐ Never

Examples: _____

Lunch

Do you have lunch every day? ☐ Always ☐ Sometimes ☐ Never

Examples: _____

Do you have a snack before lunch? ☐ Always ☐ Sometimes ☐ Never

Examples: _____

Dinner

Do you have dinner every night? ☐ Always ☐ Sometimes ☐ Never

Examples: _____

Do you have a snack before bed? ☐ Always ☐ Sometimes ☐ Never

What time: _____

Examples: _____

Do you prefer: ☐ Sweet foods ☐ Salty foods ☐ Fatty foods ☐ Vegetarian

How many glasses of water do you drink a day? _____

How much coffee do you drink a day? _____

Do you smoke? ☐ Yes ☐ No Do you vape nicotine? ☐ Yes ☐ No How many years? _____

If yes, how many packs/pulls per day? _____

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Metabolic Weight Loss Profile

Home Testing

Adrenal Fatigue Test

Adrenal glands produce hormones that help regulate your metabolism, immune system, blood pressure, response to stress, digestive health, and other essential functions.

Check all the boxes that apply to you.

Add up the boxes and place that number in the box below.

- ☐ I am frequently tired.
- ☐ I feel tired even after 8 to 10 hours of sleep.
- ☐ I am chronically stressed.
- ☐ It is difficult for me to handle stress.
- ☐ I am a night-shift worker.
- ☐ I work long hours.
- ☐ I have little relaxation time during my days.
- ☐ I get headaches frequently.
- ☐ I don't exercise consistently.
- ☐ I am or have been an endurance athlete (or participate in CrossFit).
- ☐ I have erratic sleep patterns.
- ☐ I wake up in the middle of the night.
- ☐ I crave salt.
- ☐ I have high sugar intake.
- ☐ I have difficulty concentrating.
- ☐ I carry weight in my midsection (an apple-shape body).
- ☐ I have low blood sugar issues (hypoglycemia).
- ☐ I have irregular periods.
- ☐ I have a low libido.
- ☐ I have PMS or perimenopausal/menopausal symptoms.
- ☐ I get sick frequently.
- ☐ I have low blood pressure.
- ☐ I have muscle fatigue or weakness.
- ☐ I rely on caffeine for energy (coffee, energy shots, etc.).

TOTAL

CANDIDA QUESTIONNAIRE

	YES	NO
1. Have you taken repeated or prolonged courses of antibacterial drugs?	4	0
2. Have you been bothered by recurrent vagina, prostate or urinary infections?	3	0
3. Do you feel “sick all over,” yet the cause hasn’t been found?	2	0
4. Are you bothered by hormone disturbances? *(PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature, or fatigue)*	2	0
5. Are you unusually sensitive to tobacco smoke, perfumes, and other chemical odors?	2	0
6. Are you bothered by memory or concentration problems?	2	0
7. Have you taken prolonged courses of prednisone or other steroids?	1	0
8. Have you taken birth control for more than 3 years?	1	0
9. Do you suffer with constipation, diarrhea, bloating or abdominal pain?	1	0
10. Does your skin itch, tingle or burn, is it unusually dry; or are you bothered by rashes?	1	0
11. When you wake up, do you have a white coating on your tongue?	1	0

Total

WOMEN

A score of 10 or greater indicates that your health problems may be connected to a Candida overgrowth. A score of 13 or higher suggests that your symptoms are very likely to be related to Candida.

MEN

A score of 8 or greater indicates that your health problems may be connected to a Candida overgrowth.

CANDIDA SPITTLE TEST

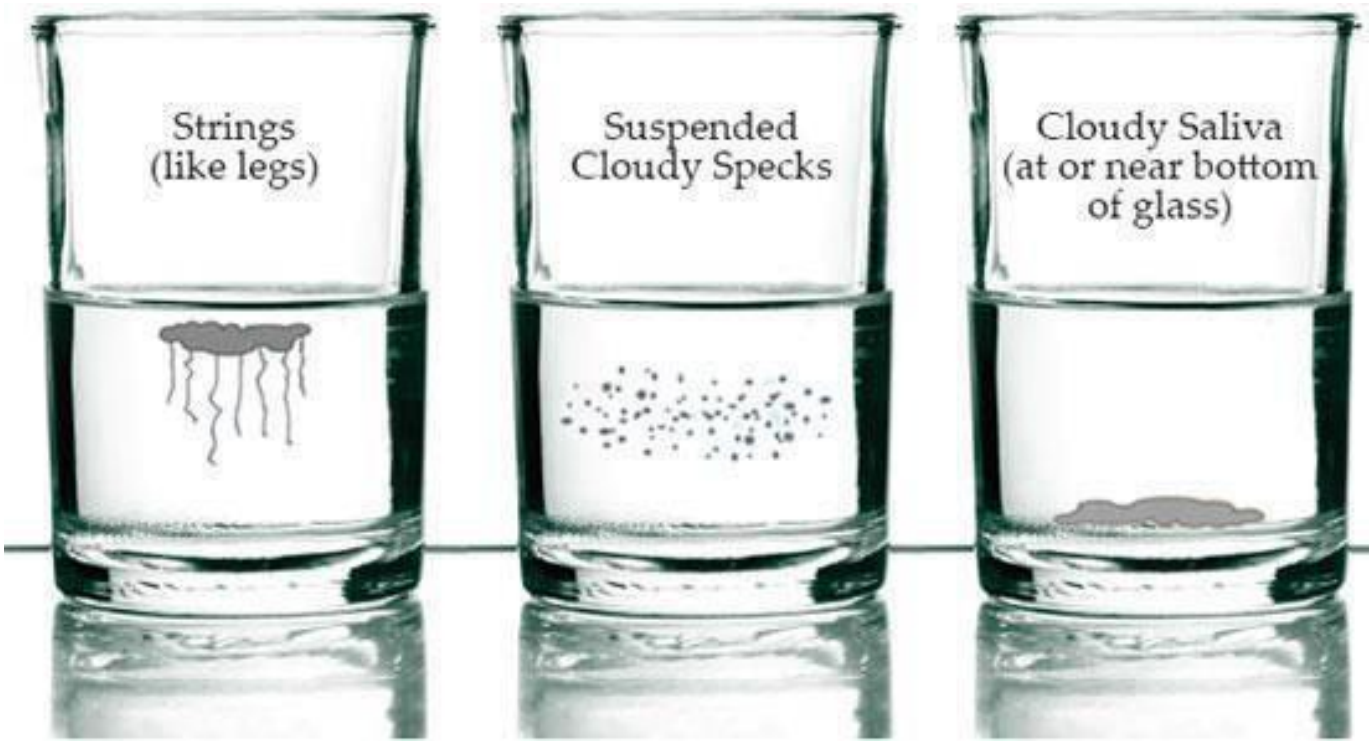
This simple, at home test will help shine some light on your current candida levels. Below are the instructions to complete this test.

1. Take a clear glass of tap water and place it on your bedside table before you go to bed.

2. The next morning, before you do anything, gently spit into the glass.

3. Check in to see the progress of your saliva every 15 minutes for one hour.

4. If your saliva does any variation of the three pictures below, that is a sign of candida overgrowth. If it stays grouped at the top or disperses, that is a sign of little to no candida overgrowth.



My saliva resembled one of the pictures above.

My saliva dispersed or stayed groupe at the top.

If the results of this test need to be provided before an appointment please call them in and leave a message at 630-238-8200 or email frontdesk@dupagehealthcareltd.com