

The Institute of Nutritional Science Weight Management Test

Member's Name _____ Date _____

Age _____ Height _____ Weight _____

Address: _____

Telephone: _____ Email: _____

Club Owner/Manager _____ Club Telephone _____

Owner/Manager's email _____ (we will only respond via email)

Test One: Carbohydrate Sensitivity

Check off each symptom that occurs with any degree of regularity

- | | |
|--|---|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Needless worrying |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Mental Confusion |
| <input type="checkbox"/> Fatigue & Exhaustion | <input type="checkbox"/> Rapid pulse, especially after eating certain foods |
| <input type="checkbox"/> Faintness, dizziness, cold sweats, shakiness, weak spells | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Antisocial behavior |
| <input type="checkbox"/> Drowsiness, especially after meals or in mid-afternoon | <input type="checkbox"/> Over-emotional, crying spells |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Lack of sex drive |
| <input type="checkbox"/> Digestive disturbances with no obvious cause | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shortness of breath, sighing and excess yawning |
| | <input type="checkbox"/> Cravings for starch and sugar-rich foods |

Please list any medications you are currently taking AND the condition for which you take them:

Circle each statement that most accurately applies to you.

Test Two: Calorie Sensitive Test

1. You had a normal body weight when younger, but slowly gained weight after age 30
2. You are presently overweight but by 25 pounds or less.
3. You have a normal appetite. (get hungry at mealtimes)
4. You have few, if any food cravings.
5. You have maintained the same basic eating habits all your life.
6. You eat three meals a day.
7. You have gained a certain amount of extra body weight but seem to have tapered off (not continued to steadily gain more and more weight).
8. You have few or none of the symptoms associated with poor carbohydrate metabolism as discussed in test one.

Test Three: Carbohydrate Intolerant Test

1. You are more than 25 pounds overweight.
2. You have had a tendency to be overweight all your adult life.
3. You have been overweight since you were younger.
4. You have a poor appetite and skip meals often
5. You prefer not to eat in the morning.
6. You have food cravings that temporarily go away when starchy or sugary foods are eaten.
7. There are foods that you feel you could absolutely not do without.
8. Your waist is bigger than your hips (men). Your waist is more than twice the size of your hips (women).
9. Most or all of the symptoms associated with carbohydrate intolerance and/or excess stress on test One apply to you.

Are you, or have you in the past year, taken any of the following classes of medications?

- | | |
|--|---|
| <input type="checkbox"/> Thiazide Diuretics | <input type="checkbox"/> Beta-Blockers |
| <input type="checkbox"/> Steroids ie.prednisone or cortisone | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Epinephrine containing medications | <input type="checkbox"/> Anti-anxiety drugs |
| <input type="checkbox"/> Anti-depression drugs | <input type="checkbox"/> Diabetes medications |
| <input type="checkbox"/> Statin (cholesterol) medications | <input type="checkbox"/> Diet pills containing caffeine |

Test Four: Insulin Profile

	Yes	No
1. Do you exercise? If yes, how often/ what type? _____	_____	_____
2. Do you consume Diet soft drinks? How many per day? _____	_____	_____
3. Do you consume alcoholic beverages? How many? _____	_____	_____
4. Do you use artificial sweeteners? Which Brands? _____	_____	_____
5. Do you smoke cigarettes or cigars? Quantity? _____	_____	_____
6. Do you consume coffee? How many cups per day? _____	_____	_____
7. How many meals do you consume daily? _____	_____	_____
8. Do you snack between meals?	_____	_____
9. Do you use low carb/low calorie diet foods? If so how often? _____	_____	_____
10. Do you have any food cravings?	_____	_____

Please list in order of craving intensity _____
_____.

Do you have now or have you ever had any of the following:

- _____ Frequent cravings for sweet or salty, crunchy snack foods
- _____ Difficulty losing weight even if you exercise or cut back on your foods
- _____ Difficult with weight gain even when eating small amounts of food
- _____ Weight gain mostly around your waist
- _____ Skin tags (small, painless, floppy skin growths)
- _____ High triglycerides levels
- _____ Low HDL (good) cholesterol
- _____ High LID (bad) cholesterol
- _____ Afternoon Fatigue
- _____ High uric acid or gout
- _____ History or having blood clots in the legs, lungs or brain
- _____ Native-American, Asian, African-American, Pacific Islander or Hispanic Ancestry
- _____ Family history of type II diabetes or hypoglycemia
- _____ List family members _____

Please list any dietary supplements you are currently taking:

Please list any diet programs you have followed in the past and the results you have obtained from them.

Comments: (provide any additional information you feel may be helpful to us)

Please check off any, in each group, that apply:

Group One

- Depression
- Fatigue
- Decreased sex drive
- Increased appetite
- Cravings for salt, fat, chocolate or caffeine
- Chronic allergies, headaches, muscle aches
- Premenstrual breast tenderness

Group Two

- Anxiety
 - Irritability
 - Anger
 - Restlessness
 - Difficulty knowing when full
 - Cravings for bread, pasta etc.
 - Cravings for alcohol or nicotine
 - Premenstrual appetite changes
 - Psoriasis
-