THE 1: DIET

Personal Record Form

This will be completed by the consultant for each dieter. Please use this form with the Medical Protocol and Advisory Notes.



| 1. Contact Details | 2. Personal Details | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| Name | Age DOB | Gender |
| Address | Occupation | |
| | Typical weekly activity/ex □Sedentary □Modera | |
| Email | Previous dieter? □Yes □ | □No |
| Phone | Height Waist | Weight BMI |
| 3. Medical Information | | |
| Does the client have any of the followin Contraindicated Alcoholic/substance misuser within one year of recovery Anti-obesity medication Serious illness, trauma or surgery (within the last three months) Serious mental health episode; such as schizophrenia, delusional disorder, psychotic episode, bi-polar disorder (within the last six months) Current active anorexia, bulimia, or currently undergoing treatment for any eating disorder Heart failure/attack, arrhythmia, valve disease requiring treatment (within the last three months) MAOI medication Stroke or TIA (within the last three months) Pregnant, breastfeeding or given birth in the last three months Requires MEF Diabetes Type 1 Diabetes Type 2 (controlled by more than Metformin) Gastric surgical procedures (within one year) Step 4 minimum & Monitoring letter Fertility medication Step 3 minimum Smoking cessation medication (such as Champix) Stomach ulcer | Step 1B minimum Spinal conditions (Such as treated with medication Neuro/muscular condition Anaemia | ic medication disease, ulcerative colitis, IBS |
| 4. Client Declaration | | 5. Consultant |
| declaration: processing. 1. The information given is correct and I have been 5. I am aware | hat it is my responsibility as a e regular medical reviews with exception adjustments. | I will abide by the Code of Conduct (CRL202) |
| weight loss programme. my GP to ass | | Name |
| 2. I understand the importance of following the 6. I have been s | | ID No |
| my Consultant and additional literature supplied Consultant | and I have read and understood o completing this form. | Phone |
| 3. If my health status/medication changes while Client agreement | | O Monitering letter sent |
| Consultant O Learneant to | the above statements | O MEF sent |

O I consent to my Consultant contacting me at

any point regarding my weight loss journey, promotions and any business opportunities. If I

wish to withdraw my consent at any stage I can

Date

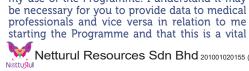
do so by sending an email to my Consultant.

Signed_

O N/A

Signed

Date



Consultant.

4. I understand that there is a legitimate interest in

The 1:1 and my Consultant holding the data on the Personal Record Form in conjunction with

my use of the Programme. I understand it may