Tripti Gupta's iPink™
The Color Of Health

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Date :____ / ____ / 201___

Ref. By :_____ Program :_____ Amount Paid :_____

PERSONAL INFORMATION (Please fill the following in block letters)

Name :_____

Address :_____

Res. No. :_____ Mobile No. :_____ Email ID :_____

FB ID :_____ Date of Birth : _____ Age : _____ Height : _____ cms

Weight : _____ Body fat % : _____ BMR : _____ VFA % : _____ BMI : _____ Blood Group : _____

Profession :_____ Designation :_____ Company :_____

MEDICAL INFORMATION (Please tick whichever applicable)

- ☐ Asthma
- ☐ Thyroid
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Sinusitis / Bronchitis
- ☐ Anemia
- ☐ Acidity / Heartburn / Gas
- ☐ Constipation
- ☐ Low immunity
- ☐ Low stamina
- ☐ Hormonal imbalance / PCOD
- ☐ Migraine
- ☐ Cholesterol
- ☐ Arthritis / Osteoporosis
- ☐ Serum Uric Acid
- ☐ Serum insulin
- ☐ Oedema (Water retention)

Past H/O Surgery / Accident / Infertility / Sterility / Chronic Bedridden Immobility :

_____

H/O Chronic Medication / Oral Contraceptives / Steroids / Pain Killers / Fat Burners :

_____

Family H/O Medical Conditions (Blood Relations only) :

_____

Any other information you would like to share with us :

_____

EATING HABITS

☐ Vegetarian ☐ OVO-Veg ☐ Non. Vegetarian ☑ Jain

Food Allergies / Dislikes : _____

Taste Preferences : Sweet / Spicy / Sour / Salty : _____

Vitamins / Medications if any : _____

DIET RECALL PLAN

For Example:

MEAL	ITEM	AMOUNT
Wake up - 7:00 a.m.	Tea w/out sugar + Marie	1 cup + 2
Breakfast - 9:00 a.m.	Toast + egg omlette	2 slices + 2 egg whites

MEAL	ITEM	AMOUNT

Water in Liters / Day : _____

Intake of Alcohol / Smoking / Tobacco / Others : _____

Physical Sctivity per day : _____