Health Profile

Date: _____

Dietary consultation involves a health profile. The purpose of the health profile is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weight loss plan. A client may be advised to seek medical advice based on his or her health profile.

Overall (Please use print characters)

First name: _____ Last name: _____

Address: _____ Apt. /unit: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____

Email: _____

Date of birth: _____ **Age**: _____

Profession: _____ Referral: _____

Current weight (lb): _____ Weight 1 year ago (lb): _____

Minimum adult weight (lb): _____ At age: _____

Maximum adult weight (lb): _____ Height: _____

Do you exercise? ☐ Yes ☐ No If yes, what kind? _____

How often? ☐ Daily ☐ Weekly ☐ Other: _____

Have you been on a diet before? ☐ Yes ☐ No

If yes, please specify which diet(s) and why you think it didn't work for you (i.e. too rigid, too much cooking involved, etc.)

_____

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight with Ideal Protein's professionally supervised weight loss method: (circle one)

Least important **1 2 3 4 5 6 7 8 9 10** Very important

What is your marital status? ☐ Married ☐ Single ☐ Other ☐ Divorce ☐ Widow

How many children do you have? _____ How old are they? _____

Who does most of the cooking at home? _____

On average, how many hours do you sleep per night? _____

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Overall (continued)

Who is your primary care physician (family doctor)?

Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr.		Specialty:		Patient since:	(MM/YY)
Dr.		Specialty:		Patient since:	(MM/YY)
Dr.		Specialty:		Patient since:	(MM/YY)
Dr.		Specialty:		Patient since:	(MM/YY)
Dr.		Specialty:		Patient since:	(MM/YY)
Dr.		Specialty:		Patient since:	(MM/YY)

Diabetes

Do you have diabetes? ☐ Yes ☐ No If not, please skip to next section.

Which type?
- ☐ **Type I – Insulin-dependent (insulin injections only)**
- ☐ Type II – Non-insulin-dependent (diabetic pills)
- ☐ Type II – Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored? ☐ Yes ☐ No If so, how often? _____

If so, by whom? ☐ Myself ☐ Physician ☐ Other – please specify: _____

Do you tend to be hypoglycemic? ☐ Yes ☐ No

NOTE: If you are currently on a Sodium-Glucose Co-Transporter inhibitor (SGLT-2), do not start the weight loss method.

Cardiovascular Function

Have you had any of the following conditions?

- ☐ Arrhythmia (NPA - if not on Rx medication)
- ☐ Blood Clot (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Heart attack (NPC)
- ☐ Heart Valve Problem (NPA)
- ☐ Heart Valve Replacement (porcine/ mechanical) (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Hyperkalemia (High potassium) (NPA)
- ☐ Hypokalemia (Low potassium) (NPA)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Stroke or Transient Ischemic Attack (NPA)
- ☐ Congestive Heart Failure (NPC)

Please select one (if applicable):
- ☐ History of Congestive Heart Failure
- ☐ Current Congestive Heart Failure (NPC)

Have you ever had **any** type of heart surgery? ☐ Yes ☐ No

If so, which type? _____

Other conditions:

If you have answered yes to any of the above conditions, please give **all** dates of occurrence:

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Kidney Function

Have you had any of the following conditions:

- ☐ Kidney Disease (NPA) Date: _____
- ☐ Kidney Transplant (NPA)
- ☐ Kidney Stones Date: _____
- ☐ Do you have Gout? ☐ Yes ☐ No If so, since when? _____

If so, what medication has been prescribed?

If no, have you ever had Gout? ☐ Yes ☐ No If so, since when? _____

If yes to any of these events, please give dates of events. For multiple events please specify:

Liver Function

Have you ever had any liver conditions? ☐ Yes ☐ No Date: _____

If yes, please list: _____

Colon Function

Do you have any of the following conditions:

- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis

If yes to any of these conditions, please give dates of events. For multiple events please specify:

Digestive Function

Do you have any of the following conditions:

- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Gastric Ulcer (NPA)
- ☐ Gluten intolerance
- ☐ Heartburn
- ☐ History of Bariatric Surgery (NPA)

If so, what type of bariatric surgery? _____

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Ovarian/Breast Function

Do you currently have any of the following conditions:

- ☐ Amenorrhea
- ☐ Fibrocystic Breasts
- ☐ Heavy periods
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Menopause
- ☐ Painful periods
- ☐ Uterine Fibroma

Ovarian/Breast Function (continued)

Date of last menstrual cycle: _____

Are you taking oral contraceptive pills?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No

Endocrine Function

Do you have thyroid problems?	☐ Yes	☐ No
If so, please specify: _____		
Do you have parathyroid problems?	☐ Yes	☐ No
If so, please specify: _____		
Do you have adrenal gland problems?	☐ Yes	☐ No
If so, please specify: _____		
Have you been told you have Metabolic Syndrome?	☐ Yes	☐ No

Neurological/Emotional Function

Do you have any of the following conditions:

- ☐ Alzheimer's disease
- ☐ Anorexia (History of)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Bulimia (History of)
- ☐ Depression
- ☐ Epilepsy (NPA)
- ☐ Panic Attacks
- ☐ Parkinson's disease
- ☐ Schizophrenia

Other issues: _____

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Inflammatory Conditions

Do you have any of the following conditions:

- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Psoriasis
- ☐ Other autoimmune or inflammatory condition
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid

Cancer

Do you have cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

Have you ever had cancer? (NPC) ☐ Yes ☐ No

If so, what type and where was it located? ☐ Yes ☐ No

Is your cancer in remission? (NPC) ☐ Yes ☐ No

If so, how long have you been in remission? _____ (MM/YY)

General

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Allergies

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please specify: _____

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Eating Habits

(Please provide honest answers so that we can help you)

BREAKFAST

Do you have breakfast every morning? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before lunch? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

LUNCH

Do you have lunch every day? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack before dinner? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

DINNER

Do you have dinner every day? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Do you have a snack at night? ☐ Yes ☐ No ☐ Never

Approximate time: _____

Examples: _____

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

OTHER		
Are you a vegan?	☐ Yes	☐ No
Strict vegans do not qualify due to too many dietary restrictions.		
Are you a vegetarian?	☐ Yes	☐ No
How many glasses of **water** do you drink per day?	_____ glasses per day	
How many cups of **coffee** do you drink per day?	_____ cups per day	
Do you **smoke**?	☐ Yes	☐ No
If so, how many per day? _____ for how many years?		
Do you drink alcohol?	☐ Yes	☐ No
If so, what and how often? _____		

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Medications & Supplements

Please list all prescription medications and supplements you are currently taking.
Refer to the example in the first line

Name of medication	Milligrams* per capsule	Number of capsules per day	Number of doses per day	Prescribing doctor	Reason for taking this medication
Vitamin X	500 mg	1	1 x a day	Dr. John Doe	Omega 3

*or grams, mEq or dosage unit your doctor prescribes.

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials _____

Confirmation of Full Health Status Disclosure by the Client and Agreement to Arbitrate Disputes

I confirm that the information that I have provided and that is recorded by me on this Ideal Protein[tm] Health Profile is true, complete and accurate and that I have not withheld or otherwise omitted, whether in whole or in part, any information concerning my health status. In this respect, I confirm that I have disclosed all past and present i) physical and/or mental health problems or concerns that I have experienced, ii) diagnoses and/or surgeries that I have had, and iii) medications and supplements that were prescribed to me or that I have taken.

Without limitation to the foregoing, I specifically confirm that I do not have any of the **conditions** and that I am not taking any of the **medications specifically highlighted in purple or blue / identified as NPC or NPA on this form.** Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein[tm] Weight Loss Method if I have any of the said conditions or if I am currently taking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on the Ideal Protein[tm] Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein[tm] Weight Loss Method, and iii) provide documentation confirming the foregoing.

I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to the clinic and iii) nevertheless chose to go on the Ideal Protein[tm] Weight Loss Method without specific supervision, such decision will be completely voluntary, and I release and discharge the clinic as well as Ideal Protein of America Inc., its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releasees**") from any and all damages, liability, claims and causes of action of any nature whatsoever (including for injury, illness or death) that may result from such voluntary and informed decision.

I confirm that the Ideal Protein[tm] Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein[tm] Weight Loss Method, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein[tm] Weight Loss Method as explained to me verbally and in the materials provided to me, both before and during the period I will be following the Ideal Protein[tm] Weight Loss Method.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein[tm] Weight Loss Method limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein[tm] Weight Loss Method.

I undertake to disclose immediately to the clinic any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am on the Ideal Protein[tm] Weight Loss Method.

I specifically agree that all claims against any of the Releasees that I may have or choose to make shall only be submitted to binding arbitration under the rules and guidelines of the American Arbitration Association, and I waive any rights to pursue any claims or causes of action in any court of law. Signed in _____ (city/state), on this ____ day of _____, 20_____.

Name of witness: _____

Name of client (print) _____

_____ _____

Name and title Signature