



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.

1. General:

(Please use print characters)

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip/Postal Code: _____

Phone: _____ Cell: _____ Email: _____ @ _____

Date of Birth: ____/____/____/ **Age:** _____ * Profession: _____

Who may we thank for referring you? _____

Current Weight: _____ lbs. Height: _____ Weight 1 year ago: _____ lbs.

Minimum adult weight: _____ lbs. at age _____ Maximum adult weight: _____ lbs.

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 (e.g. too rigid, too much cooking involved, etc.): _____

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

Least important

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Very/Most Important

What is your marital status? M S D W Other Do you have children? Yes No

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

Who does most of the cooking in your house? _____

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

Who is your primary care physician (family doctor)? _____

Physician List:

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

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

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Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

2. Diabetes:

Do you have diabetes? Yes No (If not, please skip to next section)

Which type?

a. **Type I** - **Insulin-dependent (insulin injections only)**

b. Type II - Non-insulin-dependent (diabetic pills)

c. 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

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3. Cardiovascular Function:

Have you had any of the following cardiovascular conditions?

- | | |
|---|---|
| a. <input type="checkbox"/> <u>Heart Attack (NPC)</u> | h. <input type="checkbox"/> <u>Arrhythmia (NPA - if on Rx medications)</u> |
| b. <input type="checkbox"/> <u>Blood Clot (NPA)</u> | i. <input type="checkbox"/> <u>Hypertension (High blood pressure) (NPA)</u> |
| c. <input type="checkbox"/> <u>Pulmonary Embolism (NPA)</u> | j. <input type="checkbox"/> Hyperlipidemia (High cholesterol/triglycerides) |
| d. <input type="checkbox"/> <u>Stroke or TIA (NPA)</u> | k. <input type="checkbox"/> <u>Hypokalemia (Low Potassium) (NPA)</u> |
| e. <input type="checkbox"/> <u>Coronary Artery Disease (NPA)</u> | l. <input type="checkbox"/> <u>Hyperkalemia (High Potassium) (NPA)</u> |
| f. <input type="checkbox"/> <u>Heart Valve Problem (NPA)</u> | m. <input type="checkbox"/> <u>Congestive Heart Failure (NPC) -</u> |
| g. <input type="checkbox"/> <u>Heart Valve Replacement – porcine / mechanical (NPA)</u> | |
- 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 these conditions, please give dates of occurrence. For multiple conditions, please specify:

_____	_____
_____	_____
_____	_____

4. Kidney Function:

Have you had:

a. Kidney Stones Yes No Date: ___/___/___ c. Kidney Disease (NPA) Yes No Date: ___/___/___

b. Kidney Transplant (NPA) Yes No

d. 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, when? ___/___/___

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

_____	_____
_____	_____
_____	_____

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5. Liver Function:

a. Have you had any liver issues? (NPA) Yes No Date: ___/___/___

If yes, please list:

6. Colon Function:

Do you have:

- | | | | |
|-----------------------------|--|-----------------------|--|
| a. Irritable Bowel Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | d. Ulcerative Colitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Diverticulitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Crohn's Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

7. Digestive Function:

Do you have:

- | | | | |
|-------------------------------|--|-------------------------------|--|
| a. Acid Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | e. <u>Gastric Ulcer (NPA)</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Heartburn | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Celiac Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Are you Gluten intolerant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

d. History of Bariatric Surgery (NPA) Yes No

If so, what type of bariatric surgery? _____

8. Ovarian/Breast Function:

Please check the situations that apply to you currently:

- | | | | |
|------------------------|--|--------------------|--|
| a. Irregular Periods | <input type="checkbox"/> Yes <input type="checkbox"/> No | e. Menopause | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Fibrocystic Breasts | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Painful Periods | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Hysterectomy | <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Heavy Periods | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Amenorrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Uterine Fibroma | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Date of last menstrual cycle: ___/___/___/

Are you on oral birth control pills? Yes No

i. Are you pregnant? Yes No j. Are you breastfeeding? Yes No

9. Endocrine Function:

- a. Do you have thyroid problems? Yes No If so, please specify: _____
- b. Do you have parathyroid problems? Yes No If so, please specify: _____
- c. Do you have adrenal gland problems? Yes No If so, please specify: _____

Have you been told you have Metabolic Syndrome (also called "Syndrome X")? Yes No

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10. Neurological/Emotional Function:

Do any of the following apply to you?

- | | | | |
|-------------------------------|--|--------------------------|--|
| a. <u>Bipolar Disorder</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Panic Attacks | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. <u>Parkinson's disease</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Anorexia (History of) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. <u>Epilepsy (NPA)</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Bulimia (History of) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. <u>Alzheimer's disease</u> | <input type="checkbox"/> Yes <input type="checkbox"/> No | i. Schizophrenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | j. Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Other issues: _____

11. Inflammatory Conditions:

Do any of the following apply to you?

- | | | | |
|--|--|--|--|
| a. <input type="checkbox"/> Migraines | d. <input type="checkbox"/> Fibromyalgia | f. <input type="checkbox"/> Rheumatoid | g. <input type="checkbox"/> Lupus |
| b. <input type="checkbox"/> Psoriasis | e. <input type="checkbox"/> Chronic Fatigue Syndrome | h. <input type="checkbox"/> Multiple Sclerosis | i. <input type="checkbox"/> Osteoarthritis |
| c. <input type="checkbox"/> Other autoimmune or inflammatory condition | | | |

12. Cancer:

- a. Do you have Cancer? (NPC) Yes No

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

- b. Have you ever had Cancer? (NPC) Yes No

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

When was the Cancer diagnosed? ____/____/____/

- c. Is your Cancer in remission? (NPC) Yes No

If so, how long have you been in remission? _____ (mo/yrs)

13. General:

Do you have any other health problems? Yes No

If so, please specify:

14. Allergies:

Do you have any food allergies or sensitivities? Yes No

If so, please list:

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15. Eating Habits

(Please be as honest as possible so that we may better help you)

Breakfast

Do you have breakfast every morning? Yes Sometimes Never

Approximate time: _____

Examples:

Do you have a **snack** before lunch? Yes Sometimes Never

Approximate time: _____

Examples:

Lunch

Do you have lunch every day? Yes Sometimes Never

Approximate time: _____

Examples:

Do you have a **snack** before dinner? Yes Sometimes Never

Approximate time: _____

Examples:

Dinner

Do you have dinner every day? Yes Sometimes Never

Approximate time: _____

Examples:

Do you have a **snack** at night? Yes Sometimes Never

Approximate time: _____

Examples:

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Are you a vegan? **Yes** **No***(Strict Vegans do not qualify due to too many dietary restrictions)*

Are you a vegetarian?

 Yes NoHow many glasses of water do you drink per day? _____ glasses per dayHow many cups of coffee do you drink per day? _____ cups per dayDo you smoke? Yes No

If so, packs per day _____ for how many years? _____

Do you drink alcohol? Yes NoIf so, what and how often?

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16. Medications

Dear Client: Please complete this form by listing all prescription medications and supplements that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet? *	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take 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.

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**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™ 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 / underlined / identified as NPC or NPA on this form**. Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein™ 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™ Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Weight Loss Method, and iii) and 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™ 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™ Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein™ 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™ 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™ Weight Loss Method.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein™ 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™ 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™ 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 _____, 2013

Witness:

(Signed)
Name of client (print): _____

(Signed)
Name of witness: _____

Last Name: _____ First Name: _____ DOB: ____/____/____

_____ Initials