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.):____________________________________

____

____

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)

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

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

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

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

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

Last Name: ____________________________ First Name: _________________________ DOB: ____/____/____/

________ Initials

3. Cardiovascular Function:

Have you had any of the following cardiovascular conditions?

a. ☐ **Heart Attack** **(NPC)**
b. ☐ **Blood Clot** **(NPA)**
c. ☐ **Pulmonary Embolism** **(NPA)**
d. ☐ **Stroke or TIA** **(NPA)**
e. ☐ **Coronary Artery Disease** **(NPA)**
f. ☐ **Heart Valve Problem** **(NPA)**
g. ☐ **Heart Valve Replacement – porcine / mechanical** **(NPA)**
h. ☐ **Arrhythmia** **(NPA - if on Rx medications)**
i. ☐ **Hypertension (High blood pressure)** **(NPA)**
j. ☐ Hyperlipidemia (High cholesterol/triglycerides)
k. ☐ **Hypokalemia (Low Potassium)** **(NPA)**
l. ☐ **Hyperkalemia (High Potassium)** **(NPA)**
m. ☐ **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 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:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Last Name: ______________________________ First Name: ___________________________ DOB: ____/____/____/

________ Initials

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 ☐ Yes ☐ No
b. Diverticulitis ☐ Yes ☐ No
c. Constipation ☐ Yes ☐ No
d. Ulcerative Colitis ☐ Yes ☐ No
e. Crohn's Disease ☐ Yes ☐ No
f. Diarrhea ☐ Yes ☐ 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 ☐ Yes ☐ No
b. Heartburn ☐ Yes ☐ No
c. Are you Gluten intolerant? ☐ Yes ☐ No
d. History of Bariatric Surgery (NPA) ☐ **Yes** ☐ **No**
If so, what type of bariatric surgery? ____
e. Gastric Ulcer (NPA) ☐ **Yes** ☐ **No**
f. Celiac Disease ☐ Yes ☐ No

8. Ovarian/Breast Function:

Please check the situations that apply to you currently:

a. Irregular Periods ☐ Yes ☐ No
b. Fibrocystic Breasts ☐ Yes ☐ No
c. Hysterectomy ☐ Yes ☐ No
d. Amenorrhea ☐ Yes ☐ No
e. Menopause ☐ Yes ☐ No
f. Painful Periods ☐ Yes ☐ No
g. Heavy Periods ☐ Yes ☐ No
h. Uterine Fibroma ☐ Yes ☐ 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

Last Name: ______________________________ First Name: ___________________________ DOB: ____/____/____/

_________ Initials

10. Neurological/Emotional Function:

Do any of the following apply to you?

a. Bipolar Disorder	☐ Yes ☐ No	f. Panic Attacks	☐ Yes ☐ No
b. Parkinson's disease	☐ Yes ☐ No	g. Anorexia (History of)	☐ Yes ☐ No
c. Epilepsy (NPA)	☐ Yes ☐ No	h. Bulimia (History of)	☐ Yes ☐ No
d. Alzheimer's disease	☐ Yes ☐ No	i. Schizophrenia	☐ Yes ☐ No
e. Depression	☐ Yes ☐ No	j. Anxiety	☐ Yes ☐ No

Other issues: ____

11. Inflammatory Conditions:

Do any of the following apply to you?

a.☐ Migraines d. ☐ Fibromyalgia f. ☐ Rheumatoid g. ☐ Lupus

b.☐ Psoriasis e. ☐ Chronic Fatigue Syndrome h. ☐ Multiple Sclerosis i. ☐ Osteoarthritis

c.☐ 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:

____ ____

____ ____

Last Name: ______________________________ First Name: ___________________________ DOB: ____/____/____/

________ Initials

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:

____
____
____

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, packs per day _______________ for how many years? _____________

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often?

____

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.

Last Name: _______________________________ First Name: ____________________________ DOB: ____/____/____/

________ 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™ 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 talking 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