



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? <input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, what kind? _____
How often? <input type="checkbox"/> Daily	<input type="checkbox"/> Weekly <input type="checkbox"/> Other: _____
Have you been on a diet before? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/>	Married	<input type="checkbox"/>	Single	<input type="checkbox"/>	Other					
	<input type="checkbox"/>	Divorce	<input type="checkbox"/>	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?

<input type="checkbox"/> Arrhythmia (NPA - if not on Rx medication)	<input type="checkbox"/> Hyperkalemia (High potassium) (NPA)
<input type="checkbox"/> Blood Clot (NPA)	<input type="checkbox"/> Hypokalemia (Low potassium) (NPA)
<input type="checkbox"/> Coronary Artery Disease (NPA)	<input type="checkbox"/> Hypertension (High blood pressure) (NPA)
<input type="checkbox"/> Heart attack (NPC)	<input type="checkbox"/> Pulmonary Embolism (NPA)
<input type="checkbox"/> Heart Valve Problem (NPA)	<input type="checkbox"/> Stroke or Transient Ischemic Attack (NPA)
<input type="checkbox"/> Heart Valve Replacement (porcine/mechanical) (NPA)	<input type="checkbox"/> Congestive Heart Failure (NPC)
<input type="checkbox"/> Hyperlipidemia (High cholesterol/triglycerides)	Please select one (if applicable):
	<input type="checkbox"/> History of Congestive Heart Failure
	<input type="checkbox"/> 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) Date: _____
- Kidney Stones
- 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? _____

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Ovarian/Breast Function

Do you currently have any of the following conditions:

- | | |
|--|--|
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anorexia (History of) | <input type="checkbox"/> Epilepsy (NPA) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Bulimia (History of) | <input type="checkbox"/> Schizophrenia |

Other issues: _____

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Inflammatory Conditions

Do you have any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Other autoimmune or inflammatory condition | |

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: _____

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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: _____

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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? _____

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**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.

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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 / 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) 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 _____, 20 ____.

Name of witness: _____

Name of client (print) _____

Name and title

Signature