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.

Legend (For clinic use)

NPA - Needs Prescriber Approval	**NPC -** Needs Prescriber Care

1. Overall (Please use print characters)

First name: ____________________ Last name: ____________________

Address: ____________________ Apt./unit: __________

City: ____________________ State: ______ Zip code: __________

Phone: ____________________ Mobile: ____________________

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 ☐ Widow ☐ Divorce ☐ Other: __________

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?

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1. 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)

2. Diabetes ☐ N/A

Do you have diabetes? ☐ Yes ☐ No If no, 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.

3. Cardiovascular Function ☐ N/A

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: ______

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4. Kidney Function ☐ N/A

Have you had any of the following conditions:

- ☐ Kidney Disease (NPA)
- ☐ Kidney Transplant (NPA)
- ☐ Kidney Stones
- ☐ Do you presently have gout? ☐ Yes ☐ No Since when: ____________

If yes, what medication has been prescribed? ______________________________

If no, have you ever had gout? ☐ Yes ☐ No

If yes, when? ____________________

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

____

____

5. Liver Function ☐ N/A

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

If yes, please list: ______________________________________

Have you ever had a gallstone incident? ☐ Yes ☐ No

6. Colon Function ☐ N/A

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:

____

____

7. Digestive Function ☐ N/A

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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8. Ovarian/Breast Function ☐ N/A

Do you currently have any of the following conditions:

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

Date of last menstrual cycle: ____________________

Are you taking oral contraceptive pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

9. Endocrine Function ☐ N/A

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

10. Neurological/Emotional Function ☐ N/A

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: _______

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11. Inflammatory Conditions ☐ N/A

Do you have any of the following conditions:

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

12. Cancer ☐ N/A

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 is it located? ______________________________

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

If so, how long have you been in remission? ______________ (mm/yy)

13. General ☐ N/A

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

If so, please specify: ______________________________

____

14. Allergies ☐ N/A

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

If so, please specify: ______________________________

____

____

Last name: ______________________ First name: ______________________ DOB: __________ (DD/MM/YY) Initials: _______

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15. Eating Habits

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

BREAKFAST

Do you have breakfast every morning? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

Do you have a snack before lunch? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

LUNCH

Do you have lunch every day? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

Do you have a snack before dinner? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

DINNER

Do you have dinner every day? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

Do you have a snack at night? ☐ Yes ☐ Sometimes ☐ No ☐ Never
Approximate time: ______________
Examples:

____

____

OTHER

Last name: ______________________ First name: ______________________ DOB: __________ (DD/MM/YY) Initials: _______

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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 ☐ No

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? ____________________

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

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16. 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 / 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, its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releases**") 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 Releases that I may have or choose to make shall only be submitted to binding arbitration under the rules of the Arbitration Act or similar statute of my province of residence, 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

Last name: ______________________ First name: ______________________ DOB: __________ (DD/MM/YY) Initials: _______

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