



## 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.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_/

\_\_\_\_\_ Initials

**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 - Insulin dependent (diabetic pills and insulin) / Non-insulin dependent (diabetic pills)

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. <input type="checkbox"/> Heart Attack (NPC)                                   | h. <input type="checkbox"/> Arrhythmia (NPA - if on Rx medications)         |
| b. <input type="checkbox"/> Blood Clot (NPA)                                     | i. <input type="checkbox"/> Hypertension (High blood pressure) (NPA)        |
| c. <input type="checkbox"/> Pulmonary Embolism (NPA)                             | j. <input type="checkbox"/> Hyperlipidemia (High cholesterol/triglycerides) |
| d. <input type="checkbox"/> Stroke or TIA (NPA)                                  | k. <input type="checkbox"/> Hypokalemia (Low Potassium) (NPA)               |
| e. <input type="checkbox"/> Coronary Artery Disease (NPA)                        | l. <input type="checkbox"/> Hyperkalemia (High Potassium) (NPA)             |
| f. <input type="checkbox"/> Heart Valve Problem (NPA)                            | m. <input type="checkbox"/> Congestive Heart Failure (NPC) -                |
| g. <input type="checkbox"/> Heart Valve Replacement – porcine / mechanical (NPA) |   |
- 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 | <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. Gastric Ulcer (NPA) | <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: \_\_\_/\_\_\_/\_\_\_/

i. Are you pregnant? (NPA)  Yes  No

j. Are you breastfeeding? (NPA)  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. <b>Bipolar Disorder</b>    | <input type="checkbox"/> Yes <input type="checkbox"/> No | f. Panic Attacks         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. <b>Parkinson's disease</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No | g. Anorexia (History of) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. <b>Epilepsy (NPA)</b>      | <input type="checkbox"/> Yes <input type="checkbox"/> No | h. Bulimia (History of)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. <b>Alzheimer's disease</b> | <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?**  Yes  No (NPC)

If so, what type and where is it located? \_\_\_\_\_

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

If so, what type and where is it located? \_\_\_\_\_

When was the Cancer diagnosed? \_\_\_/\_\_\_/\_\_\_/

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

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:

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

Approximate time: \_\_\_\_\_

Examples:

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### Lunch

Do you have lunch every day?  Yes  Sometimes  Never

Approximate time: \_\_\_\_\_

Examples:

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

Approximate time: \_\_\_\_\_

Examples:

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### Dinner

Do you have dinner every day?  Yes  Sometimes  Never

Approximate time: \_\_\_\_\_

Examples:

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

Approximate time: \_\_\_\_\_

Examples:

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_/

\_\_\_\_\_ Initials

Are you a **vegan**?

Yes  No

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?

\_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_/

\_\_\_\_\_ Initials

## 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 / 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