BioIntelligent Wellness

Phone: 858 228 3644
Fax: 760.994.1248
www.BioIntelligentWellness.com

Solana Beach
124 Lomas Santa Fe, Suite 206
Solana Beach CA 92075

Carlsbad
7220 Avenida Encinas, Suite 110-B,
Carlsbad, CA 92011

Health Profile

Date ____________

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.

Personal Information

Please use print characters

Full Name ____________ Date of Birth ____________ Age ____________

Address ____________ Apt/Unit: # ____________ City ____________

State ____________ Zip/Postal Code ____________

E-mail ____________ Phone ____________ Cell ____________

Profession ____________ Who may we thank for referring you? ____________

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Your Data

Please use print characters

Current Weight (lbs) ____________

Height (cm) ____________

Weight 1 year ago (lbs) ____________

Minimum adult weight (lbs) / at age ____________

Maximum adult weight (lbs) / at age ____________

☐ **I exercise**

What kind? ____________

How often (daily, weekly, other)? ____________

☐ **I have been on a diet before**

What kind? ____________

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)

1 2 3 4 5 6 7 8 9 10 (Most Important)

Marital status (Married / Single / Widow(er) / Divorced / Dating) ____________

☐ **I have children**

How many and how old are they ____________

Who does most of the cooking in your house? ____________

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

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You Physicians

Please list any physicians you see and their specialty

Who is your primary care physician (family doctor)?

____

Physician List

Doctor	Specialty	Patient since (month / year)

Diabetes

Please use print characters

☐ **I have diabetes**

Which type?

☐ **Type I** (Insulin dependent (insulin injections only))

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

☐ **My blood sugar level monitored**

How often and by whom (Myself, Physician)?

____

☐ **I tend to be hypoglycemic**

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Cardiovascular Function

Have you had any of the following cardiovascular conditions?

- ☐ Heart Attack (NPC)
- ☐ Blood Clot (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Stroke or TIA (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Heart Valve Problem (NPA)
- ☐ Heart Valve Replacement – porcine / mechanical (NPA)
- ☐ Arrhythmia (NPA - if on Rx medications)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Hypokalemia (Low Potassium) (NPA)
- ☐ Hyperkalemia (High Potassium) (NPA)
- ☐ Congestive Heart Failure (NPC)

Please select one (if applicable)

- ☐ History of Congestive Heart Failure
- ☐ Current Congestive Heart Failure

☐ **Ever had ANY type of heart surgery?**

Which type?

____

**If you have answered yes to any of these conditions, please give dates of occurrence.
For multiple conditions, please specify**

____

____

____

Kidney Function:

Have you had

☐ **Kidney Stones**

Date ______________

☐ **Kidney Transplant(NPA)**

Date ______________

☐ **Kidney Disease (NPA)**

Date ______________

☐ **Do you have /ever had Gout?**

Since when and till when?

____

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What prescription medications are you taking?

____

If you have have other events, please give dates. For multiple events please specify:

____
____
____

Liver Function

Have you had

- [ ] **Liver issues? (NPA)**

Date ______________

If yes, please list:

______________ ______________
______________ ______________
______________ ______________

Colon Function:

Which of the following do you have now?

- [ ] **Irritable Bowel Syndrome**
- [ ] **Diverticulitis**
- [ ] **Constipation**
- [ ] **Ulcerative Colitis**
- [ ] **Crohn's Disease**
- [ ] **Diarrhea**

If you have have other events, please give dates. For multiple events please specify:

____
____
____

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Digestive Function

Do you have

- ☐ Acid Reflux
- ☐ Gastric Ulcer (NPA)
- ☐ Heartburn
- ☐ Celiac Disease
- ☐ Are you Gluten intolerant?
- ☐ History of Bariatric Surgery (NPA)

If so, what type of bariatric surgery?

____

Ovarian/Breast Function

Please check the situations that apply to you currently

- ☐ Irregular Periods
- ☐ Menopause
- ☐ Fibrocystic Breasts
- ☐ Painful Periods
- ☐ Hysterectomy
- ☐ Heavy Periods
- ☐ Amenorrhea
- ☐ Uterine Fibroma
- ☐ I'm pregnant? (NPA)
- ☐ I'm breastfeeding? (NPA)

Date of last menstrual cycle

____

Tyroid Function

- ☐ I have thyroid problems?

If so, please specify

____

- ☐ I have parathyroid problems?

If so, please specify

____

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Metabolic Function

☐ **I have adrenal gland problems?**

If so, please specify

☐ **I have ever been told I have Metabolic Syndrome (also called "Syndrome X")?**

Neurological/Emotional Function

Do any of the following apply to you?

- ☐ **Bipolar Disorder**
- ☐ **Parkinson's disease**
- ☐ **Epilepsy (NPA)**
- ☐ **Alzheimer's disease**
- ☐ **Depression**
- ☐ **Panic Attacks**
- ☐ **Anorexia (History of)**
- ☐ **Bulimia (History of)**
- ☐ **Schizophrenia**
- ☐ **Anxiety**

Other issues

Inflammatory Conditions:

Do any of the following apply to you?

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

If so, please specify

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Cancer

☐ **I have Cancer**

If so, what type and where is it located?

____

☐ **I had Cancer**

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

When was the Cancer diagnosed? ____________

☐ **My Cancer is in remission**

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

____

Other Conditions:

☐ **I have other health problems**

If so, please specify

____

____

Allergies

☐ **I have food allergies or sensitivities**

If so, please list

____

____

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Eating Habits

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

Breakfast

I have breakfast in the morning

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________

____

I have a snack before lunch

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________

____

Lunch

I have lunch

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________

____

I have a snack before dinner

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________

____

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Eating Habits

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

Dinner

I have dinner every day

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________________

____

I have a snack at night?

☐ Always ☐ Not regulary ☐ Rarely ☐ Never

At what time aprroximetely ____________ Examples ____________________

____

Eating and Personal Habits

☐ **I'm a vegan** ☐ **I'm a vegetarian**

I drink ____________ **glasses of water and** ____________ **cups of coffee per day**

☐ **I'm a smoker**

How many packs per day ____________ For how many years? ____________

☐ **I drink alcohol?**

If so, what and how often?

____

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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 the Medication	mg per 1 tablet	Tablets per day	How often to take a dose?	Prescribed by whom?	Reason for Prescription
Vitamin X	500 mg	1	1 x a day	Dr. John Doe	Omega 3

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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^tm 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
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^tm 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^tm Weight Loss Method,
ii) remain under the supervision of said medical doctor while I am on the Ideal Protein^tm Weight Loss Method
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
iii) nevertheless chose to go on the Ideal Protein^tm 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

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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 agree 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 __________

Client's Signature ______________________

Name of client (print): ______________________

Witness' Signature ______________________

Name of witness ______________________