

## 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 protocol: (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? \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

# Health Profile

**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) Last visit: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Patient since: \_\_\_\_\_ (MM/YY) Last visit: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Patient since: \_\_\_\_\_ (MM/YY) Last visit: \_\_\_\_\_

Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Patient since: \_\_\_\_\_ (MM/YY) Last visit: \_\_\_\_\_

**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 Sodium-Glucose Co-Transporter inhibitor medication (SGLT-2), which include Ebymect, Edistride, Forxiga, Invokana, Jardiance, Synjardy, Vokanamet and Xigduo, **YOU CANNOT START OR BE ON IDEAL PROTEIN’S REGULAR PROTOCOL.** Please speak to your coach about our Alternative Protocol.

**3. Cardiovascular Function**  N/A

Have you had any of the following conditions?

<input type="checkbox"/> Arrhythmia (NPA)	<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)	<input type="checkbox"/> Please select one (if applicable):
	<input type="checkbox"/> History of Congestive Heart Failure
	<input type="checkbox"/> Current Congestive Heart Failure (NPC)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

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### 3. Cardiovascular Function (cont.) N/A

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:

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

### 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

Diverticulitis

Crohn's Disease

Irritable Bowel Syndrome

Diarrhea

Ulcerative Colitis

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

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

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

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**7. Digestive Function**  N/A

Do you have any of the following conditions:

- |  |   |
|--|---|
| <input type="checkbox"/> Acid Reflux         | <input type="checkbox"/> Gluten intolerance                 |
| <input type="checkbox"/> Celiac Disease      | <input type="checkbox"/> Heartburn                          |
| <input type="checkbox"/> Gastric Ulcer (NPA) | <input type="checkbox"/> History of Bariatric Surgery (NPA) |

If so, what type of bariatric surgery? \_\_\_\_\_

**8. Ovarian/Breast Function**  N/A

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   |

Date of last menstrual cycle: \_\_\_\_\_

Are you taking oral contraceptive pills?  Yes  NoAre you pregnant?  Yes  NoAre you breastfeeding?  Yes  No**9. Endocrine Function**  N/ADo 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

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**10. Neurological/Emotional Function**  N/A

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: \_\_\_\_\_  
\_\_\_\_\_**11. Inflammatory Conditions**  N/A

Do you have any of the following conditions:

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

**12. Cancer**  N/ADo 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/ADo you have any other health problems?  Yes  NoIf so, please specify: \_\_\_\_\_  
\_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

## Health Profile

### 14. Allergies N/A

Do you have any food allergies or sensitivities?  Yes  No

If so, please specify:

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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:

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Do you have a snack before lunch?  Yes  Sometimes  No  Never

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

Examples:

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#### LUNCH

Do you have lunch every day?  Yes  Sometimes  No  Never

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

Examples:

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Do you have a snack before dinner?  Yes  Sometimes  No  Never

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

Examples:

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Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

## Health Profile

**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**

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

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_

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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.

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_



## Health Profile

### Confirmation of full health status disclosure by the client and agreement to arbitrate disputes

I confirm that the information that I have provided to my Ideal Protein™ Protocol service provider (the “Clinic”) 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™ Protocol 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™ Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Protocol, 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 follow on the Ideal Protein™ Protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Clinic as well as Ideal Protein of America Inc., their parent companies, subsidiaries and affiliates and each of 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 of following the Ideal Protein™ Protocol.

I confirm that the Ideal Protein™ Protocol has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein™ Protocol, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein™ Protocol 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™ Protocol.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein™ Protocol limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein™ Protocol.

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 following the Ideal Protein™ Protocol.

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 of the Arbitration Act or similar statute of my state 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 (print):	_____
Name of client (print)	_____
_____	_____
Client Signature	Witness Signature

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ (DD/MM/YY) Initials: \_\_\_\_\_