IDEAL PROTEIN
POWERING life POSSIBLE

# Health Profile to be Completed by New Patients & Clients

| | |
|---|---|
| Today's Date: | Coach's Name: |
| Your Name: | Date: |

Dietary consultation involves a health profile, the purpose of which is not to establish a diagnosis, but rather to determine a patient or client's health status in order to guide his or her weight loss plan. A patient or client may be advised to seek medical advice based on his or her health profile. **Please click into the grey boxes to begin typing and to preserve formatting.**

**Legend (For Ideal Protein Clinic and Center use only)**

| | |
|---|---|
| **NPA** - Needs Prescriber Approval | |
| **NPA/M** – Needs Prescriber Approval *with* Medication Monitoring | **NPC** – Needs Prescriber Care (and approval) |

## 1. Personal Information

| | | |
|---|---|---|
| First name: | Last name: | |
| Address: | | Apt./Unit: |
| City: | State/Province: | Zip /Postal code: |
| Home Phone: | Mobile Phone: | |
| Email: | | |
| Date of birth: | Age: | |
| Profession: | Employer: | |
| How did you hear about us? | | |
| Referrer's Name: | | |

## 2. General Information and Lifestyle Choices

| | | | |
|---|---|---|---|
| Current weight (lbs.): | | Weight 1 year ago (lbs.): | |
| Lowest adult weight (lbs.): | | At age: | |
| Highest adult weight (lbs.): | | At age: | |
| Height (feet, inches) | | | |
| Do you exercise? | Yes No | If yes, what kind? | |
| | | How often? | |
| | | If no, why not? | |
| Have you been on a diet before? | Yes | No | |

If yes, please specify which diet(s) and why you think it did not work for you (for example, too rigid, too much cooking, etc.)

| | | |
|---|---|---|
| Are you currently a vegan? | Yes **(exclusion)** | No |
| Are you currently a vegetarian? | Yes | No |
| What is your marital status? | Married | Single / Divorced |
| 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? | | |

## 3.1 Primary Care Physician, Surgeries and Specialists Information

Who is your primary care physician (family doctor)? Name: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

When was the last time blood work was performed? Date: _____

Have you had surgery in the last 6 months? If so, what type? _____

Date:

## 3.2 Primary Care Physician, Surgeries and Specialists Information

Please list any physicians you see and their specialty:

Dr. _____ Specialty: _____

Patient since: _____ (MM/YY) Last visit:

Dr. _____ Specialty: _____

Patient since: _____ (MM/YY) Last visit:

Dr. _____ Specialty: _____

Patient since: _____ (MM/YY) Last visit:

## 4. Diabetes

N/A – Please check this box if this category does not apply to you

If so, which type?

Type I – Insulin-dependent (insulin injections only) **(NPC)**

Type II – Non-insulin-utilizing (diabetic pills) **(NPA/M)**

Type II – Insulin-utilizing (diabetic pills and insulin) **(NPA/M)**

Is your blood sugar level monitored? Yes No

If so, how? _____

What is the frequency? _____

If so, by whom? Myself Physician

Do you tend to be hypoglycemic? Yes No

## 5. Cardiovascular Function

N/A – Please check this box if this category does not apply to you

Do you have/have you had any cardiac (heart) problems (i.e. arrythmia, heart valve replacement, hypertension, heart failure?)

Yes **(NPC)** No

## 6. Metabolic Conditions

N/A – Please check this box if this category does not apply to you

Have you had or currently have any of the following conditions?

Hyperlipidemia (high cholesterol)

Gout **(NPC)** When?

Medication prescribed for your gout?

If "yes" to any of these conditions, please provide the dates and specifics of the events, if applicable:

## 7. Kidney Function

N/A – Please check this box if this category does not apply to you

Have you had or currently have any of the following conditions?

**Severe Kidney Disease (exclusion)** Kidney Disease **(NPA)**

Kidney Transplant **(NPA)** Kidney Stones Type?

If "yes" to any of these conditions, please provide the dates and specifics of the events, if applicable:

## 8. Liver Function

N/A – Please check this box if this category does not apply to you

**Severe Liver Disease (exclusion)** Chronic Liver Disease **(NPC)**

Hepatitis **(NPC)** Cirrhosis **(NPA)**

Fatty Liver Disease **(NPC)** Gallstone

Please provide dates, if applicable:

If other liver conditions, please list:

## 9. Colon Function

N/A – Please check this box if this category does not apply to you

Do you have any bowel issues (IBS, constipation, diarrhea, etc.)?

Yes (please list) No

## 10. Digestive Function

N/A – Please check this box if this category does not apply to you

Acid Reflux and /or Heartburn — Celiac Disease / Gluten intolerance

Bariatric Surgery (or history of) **(NPA)** — If surgery, what type? _____

## 11. Endocrine Function

N/A – Please check this box if this category does not apply to you

Have you had or currently have any of the following conditions?

- Thyroid issues **(NPA/M)**
- Adrenal disease
- Parathyroid issues
- Other:

If so, please specify:

## 12. Ovarian and Breast Function

N/A – Please check this box if this category does not apply to you

Do you currently have any of the following conditions?

- Irregular periods / Amenorrhea
- Hysterectomy
- Menopause
- Polycystic Ovarian Syndrome (PCOS)
- Pregnant **(NPC - OB/GYN)**
- Breastfeeding **(NPC Pediatrician)**

Date of last menstrual cycle:

Are you using any contraception? Yes No Type: _____

## 13. Neurological Function

N/A – Please check this box if this category does not apply to you

Do you have any of the following conditions?

- Alzheimer's disease or dementia **(NPA)**
- Epilepsy **(NPA)** Date of last seizure:
- Parkinson's disease **(NPA)**
- Other:

## 14. Emotional Function

N/A – Please check this box if this category does not apply to you

Do you have any of the following conditions?

- Anorexia (or history of) **(NPC)**
- Major Depression **(NPA)**
- Bulimia (or history of) **(NPC)**
- Schizophrenia **(NPC)**
- Anxiety **(NPC)**
- Other:
- Bipolar disorder **(NPC)** **(Note medications, i.e. lithium)**
- Other:

## 15. Inflammatory Conditions

N/A – Please check this box if this category does not apply to you

Do you have any of the following conditions?

- Fibromyalgia
- Multiple Sclerosis
- Lupus
- Psoriasis
- Migraines
- Rheumatoid

If any, please specify other autoimmune or inflammatory conditions:

## 16. Cancer

N/A – Please check this box if this category does not apply to you

Do you currently have cancer? **(NPC & requires written consent from by Oncologist)** Yes No

If so, what type, local or metastatic?

Is your cancer in remission? Yes **(NPA)** No

## 17. Allergies

N/A – Please check this box if this category does not apply to you

Do you have any of the following conditions?

- Food allergies — If so, please specify:
- Food intolerances
- Gluten Sensitivity — If so, please specify:
- Other: _____

## 18. Other Health Conditions

N/A – Please check this box if this category does not apply to you

Do you have any other health conditions? Yes No

If so, please specify:

## 19. Drink Consumption

Do you drink alcohol? Yes No

*** I understand that the consumption of any type of alcohol is strictly prohibited while on the Ideal Protein Protocol.**

**Initials:**

How many glasses of water do you drink per day? glasses per day

How many cups of coffee (or caffeinated tea) do you drink per day? cups per day

How much cream or milk do you use? tbsp./packets

How much sugar or sweeteners do you use? tsp./packets

How many glasses of juice do you drink per day? glasses per day

What type of juice?

How many soft drinks do you drink per day? units per day

How many sport or energy drinks do you drink per day? units per day

## 20. Eating Habits - Please provide your typical dietary habits.

**BREAKFAST**

Do you eat breakfast every morning? Yes Sometimes No

Approximate time:

Examples:

**SNACK BEFORE LUNCH**

Do you have a snack before lunch? Yes Sometimes No

Approximate time:

Examples:

**LUNCH**

Do you eat lunch every day? Yes Sometimes No

Approximate time:

Examples:

**SNACK BEFORE DINNER**

Do you have a snack before dinner? Yes Sometimes No

Approximate time:

Examples:

**DINNER**

Do you have dinner every day? Yes Sometimes No

Approximate time:

Examples:

**SNACK AT NIGHT**

Do you have a snack at night? Yes Sometimes No

Approximate time:

Examples:

## 21. Medications & Supplements

Please list all prescription medications, supplements and vitamins.
Please refer to the example in the first line.

| Name of medication and supplement | Milligrams* per capsule/tablet | Number of capsules/tablets per day | Number of doses per day | Prescribing Doctor | Reason for taking |
|---|---|---|---|---|---|
| Medication "X" | 500 mg | 1 | Once a day | Dr. John Doe | Thyroid issue |

*Or grams, mEq or dosage unit your doctor prescribes.

## 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 conditions **identified as NPA and/or NPC 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 follow 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 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 following 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.

Signed in _____ (city/state), on this _____ day of _____, 20_____.

Name of witness (print): _____

Name of client (print): _____

_____ _____

Client Signature Witness Signature

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.