

## Health Profile to be Completed by New Patients & Clients

oday's Date:	,	Coach's	Name:			
our Name:		Date:				
determine a patient or clie	ent's health status in advice based on his	order to guide his	ch is not to establish a diagroup or her weight loss plan. A page. Please click into the gre	atient or client may be		
	Legend (Fo	r Ideal Protein Clinic	and Center use only)			
NPA - Needs Prescriber App						
NPA/M - Needs Prescriber		tion Monitoring	NPC - Needs Prescriber	Care (and approval)		
1. Personal Information	on					
First name:			Last name:			
Address:				Apt./Unit:		
City:			State/Province:	Zip /Postal code:		
Home Phone:			Mobile Phone:			
Email:						
Date of birth:			Age:			
Profession:		1-996 - 1-1-1-1	Employer:			
How did you hear about u	s?					
Referrer's Name:	4					
2. General Information	and Lifestyle Ch	noices				
Current weight (lbs.):		V	/eight 1 year ago (lbs.);			
Lowest adul	t weight (lbs.):		At age:			
Highest adul	Highest adult weight (lbs.):  At age:					
Height (feet, inches)						
Do you exercise?	Yes	No	If yes, what kind?			
<u></u>	165	140				
	How often?					
H I			If no, why not?			
Have you been on a diet b		ou think it did not	Yes ork for you (for example, too	No		
etc.)	ir diet(s) and wify yo	od tillik it did flot We	ork for you (for example, too	rigia, too much cooking,		
Are you currently a vegan?	>					
, no you durining a vegan			No			
Are you currently a vegeta	rian?	Yes (exclusion	n)			
		Yes	No			
What is your marital status	?	Married	Single	Divorced		
How many children do you			How old are they?	<u> </u>		
Who does most of the cool	king at home?					
On average, how many ho	urs do you sleep pe	r night?				

Who is your primary care physician (family doctor)?  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. Patient since: (MMYYY) Last visit:  4. Diabetes N/A - Please check this box if this category does not apply to you If so, which type? If so, how? What is the frequency? If so, how? What is the frequency? If so, by whom? Myself Physician Do you tend to be hypoglycemic? S. Cardiovascular Function Do you have/have you had any cardiac (heart) problems (i.e. arrythmia, heart valve replacement, hyperter failure?) Yes (NPC) No  Metabolic Conditions N/A - Please expectatis box if this category does not apply to you we you had or currently have any of the following conditions? Medication prescribed for your gour? Medicat	o is your primary care physic	, Surgeries and S			
Fax Number: Email Address:  When was the last time blood work was performed?  Date:  Have you had surgery in the last 6 monthe?  If so, what type?  Date:  3.2 Primary Care Physician, Surgeries and Specialists Information  Please list any physicians you see and their specialty:  Dr.  Patient since:  (MMYY)  Last visit:  Dr.  Specialty:  Patient since:  (MMYY)  Last visit:  4. Diabetes  N/A - Please check this boxif this category does not apply to you  If so, which type?  If so, how?  What is the frequency?  If so, how?  What is the frequency?  If so, by whom?  Myself  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, hyperter failure?)  Yes (NPC)  No  Metabolic Conditions  N/A - Please check this box if this category does not apply to you  When?  Medication prescribed for your gout?  res" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Kidney Function  N/A - Please check this box if this category does not apply to you  ve you had or currently have any of the following conditions?  yeers' to any of these conditions, please provide the dates and specifics of the events, if applicable:  Kidney Function  N/A - Please check this box if this category does not apply to you  ve you had or currently have any of the following conditions?  Yeers (Midney Stones Type?		ian (family doctor)?	Name:	***************************************	
Email Address:  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.  Patient since:  (MMYY)  Last visit:  4. Diabetes  N/A — Please check this box if this category does not apply to you  If so, which type?  Type II — Insulin-dependent (insulin injections only) (  Type III — Insulin-utilizing (diabetic pills) (NPAM  Type III — Insulin-utilizing (diabetic pills and insulin) (  Is your blood sugar level monitored?  What is the frequency?  If so, by whom?  What is the frequency?  If so, by whom?  Myself  Physician  Do you tend to be hypoglycemic?  NA — 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, hyperter failure?)  Yes (NPC)  No  Metabolic Conditions  N/A — Please check this box if this category does not apply to you  to you had or currently have any of the following conditions?  Prepripidemia (high cholesterol)  but (NPC)  When?  Medication prescribed for your gout?  se" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Kidney Function  N/A — Please check this box if this category does not apply to you  to you had or currently have any of the following conditions?  Prepripidemia (high cholesterol)  Kidney Disease (NPA)  Kidney Disease (NPA)  Kidney Disease (NPA)  Kidney Stones  Type?			Telephone Nu	mber:	
When was the last time blood work was performed?  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 II - Insulin-utilizing (diabetic pills) (NPA/M Type II - Insulin-utilizing (diabetic pills) (NPA/M Type II - Insulin-utilizing)  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, hyperter failure?)  Yes (NPC) No  Metabolic Conditions N/A - Please check this box if this category does not apply to you  be you had or currently have any of the following conditions?  perlipidemia (high cholesterol)  but (NPC) When?  Medication prescribed for your gout?  es' to any of these conditions, please provide the dates and specifics of the events, if applicable:  es' to any of these conditions, please provide the dates and specifics of the events, if applicable:  es' to any of these conditions, please provide the dates and specifics of the events, if applicable:  es' to any of these conditions, please provide the dates and specifics of the events, if applicable:  es' to any of these conditions, please provide the following conditions?  vere Kidney Disease (exclusion) Kidney Disease (NPA)  diney Transplant (NPA)  Kidney Stones Type?			Fax Nu	mber:	
Have you had surgery in the last 6 months?  Bate:  3.2 Primary Care Physician, Surgeries and Specialists Information  Please list any physicians you see and their specialty:  Dr.  Patient since:  (MM/YY)  Last visit:  Dr.  Specialty:  Last visit:  Dr.  Patient since:  (MM/YY)  Last visit:  Dr.  Patient since:  (MM/YY)  Last visit:  Dr.  Specialty:  Last visit:  Dr.  Patient since:  (MM/YY)  Last visit:  Dr.  Specialty:  Last visit:  Dr.  Patient since:  (MM/YY)  Last visit:  Dr.  Specialty:  Last visit:  Last visit:  Last visit:  Dr.  Specialty:  Last visit:  Dr.  Specialt			Email Add	dress:	
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Please list any physicians you see and their specialty:  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 II — Insulin-utilizing (diabetic pills) (NPA/M Type II — Insulin-utilizing (diabetic pills) (NPA/M Type II — Insulin-utilizing (diabetic pills and insulin) (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, hyperter failure?)  Yes (NPC) No  fetabolic Conditions N/A — Please check this box if this category does not apply to you  be you had or currently have any of the following conditions?  perlipidemia (high cholesterol)  ut (NPC) When?  Medication prescribed for your gout?  ss" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Idiney Function N/A — Please check this box if this category does not apply to you  be you had or currently have any of the following conditions?  Vere Kidney Disease (exclusion) Kidney Disease (NPA)  Interpretation N/A — Please check this box if this category does not apply to you  be you had or currently have any of the following conditions?  Vere Kidney Disease (exclusion) Kidney Disease (NPA)  Interpretation N/A — Please check this box if this category does not apply to you  be you had or currently have any of the following conditions?  Vere Kidney Disease (exclusion) Kidney Disease (NPA)  Interpretation of the second this box if this category does not apply to you  Box to any the following conditions?					
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 II — Insulin-dependent (insulin injections only) ( Type II — Insulin-utilizing (diabetic pills) (NPA/M Type II — Insulin-u	Primary Care Physician,	Surgeries and S	pecialists Infon	mation	
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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) ( Type II - Non-insulin-utilizing (diabetic pills) (NPAM) Type II - Insulin-utilizing (diabetic pills) (NPAM) Type II - Insulin-utilizing (diabetic pills and insulin) ( 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? Myself Physician Do you have/have you had any cardiac (heart) problems (i.e. arrythmia, heart valve replacement, hyperter failure?) Yes (NPC) No  Iletabolic Conditions N/A - Please check this box if this category does not apply to you e you had or currently have any of the following conditions? Perlipidemia (high cholesterol) ut (NPC) When? Medication prescribed for your gout? es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Idiney Function N/A - Please check this box if this category does not apply to you e you had or currently have any of the following conditions? Vere Kidney Disease (exclusion) Kidney Disease (NPA) Interpretation N/A - Please check this box if this category does not apply to you e you had or currently have any of the following conditions? Vere Kidney Disease (exclusion) Kidney Disease (NPA) Interpretation N/A - Please check this box if this category does not apply to you e you had or currently have any of the following conditions? Vere Kidney Disease (exclusion) Kidney Disease (NPA) Interpretation N/A - Please Check this box if this category does not apply to you expect Kidney Disease (exclusion) Kidney Disease (NPA) Interpretation N/A - Please Check this box if this category does not apply to you expect Kidney Disease (exclusion) Kidney Disease (NPA) Interpretation N/A - Please Check this box if this category does not apply to you expect Kidney Disease (exclusion) Kidney Disease (NPA)				Specialty:	
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Do you tend to be hypoglycemic?  S. 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, hyperter failure?)  Yes (NPC)  No  N/A — Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  perlipidemia (high cholesterol)  ut (NPC)  When?  Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  idney Function  N/A — Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Stones  Type?	If so	, by whom?	Myself	Physi	cian
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, hyperter failure?)  Yes (NPC)  No  N/A — Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  perlipidemia (high cholesterol)  ut (NPC)  When?  Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  idney Function  N/A — Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA)  iney Transplant (NPA)  Kidney Stones  Type?			Yes		
Do you have/have you had any cardiac (heart) problems (i.e. arrythmia, heart valve replacement, hyperter failure?) Yes (NPC) No  No  N/A — Please check this box if this category does not apply to you end you had or currently have any of the following conditions? Derlipidemia (high cholesterol) Fig. 1. When? Medication prescribed for your gout? Ses" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Idney Function N/A — Please check this box if this category does not apply to you end you had or currently have any of the following conditions?  Fig. 2. Yere Kidney Disease (exclusion) Fig. 3. Kidney Stones Fig. 4. Kidney Stones Fig. 3. Kidney Stones Fig. 4. Kidney Stones Fig	ordiovecaular Eupatian	NI/A DI			
e you had or currently have any of the following conditions?  perlipidemia (high cholesterol)  ut (NPC) When?  Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  idney Function N/A Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion) Kidney Disease (NPA)  mey Transplant (NPA) Kidney Stones Type?	Conditions N/A n				
perlipidemia (high cholesterol)  ut (NPC) When?  Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  idney Function N/A Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion) Kidney Disease (NPA)  iney Transplant (NPA) Kidney Stones Type?			The state of the s	y to you	
Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  idney Function  N/A — Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA)  Iney Transplant (NPA)  Kidney Stones  Type?		Tollowing Conditions	11		
Medication prescribed for your gout?  es" to any of these conditions, please provide the dates and specifics of the events, if applicable:  Cidney Function  N/A - Please check this box if this category does not apply to you  e you had or currently have any of the following conditions?  evere Kidney Disease (exclusion)  Kidney Disease (NPA)  Iney Transplant (NPA)  Kidney Stones  Type?		n?			
idney Function  N/A Please check this box if this category does not apply to you e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA) Iney Transplant (NPA)  Kidney Stones  Type?					
idney Function  N/A Please check this box if this category does not apply to you e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA)  ney Transplant (NPA)  Kidney Stones  Type?		-	nd specifics of the	events, if applicable	
e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA)  ney Transplant (NPA)  Kidney Stones  Type?					
e you had or currently have any of the following conditions?  vere Kidney Disease (exclusion)  Kidney Disease (NPA)  ney Transplant (NPA)  Kidney Stones  Type?		· ·			
vere Kidney Disease (exclusion)  Kidney Disease (NPA)  ney Transplant (NPA)  Kidney Stones Type?	To be the second of the second	The state of the s	The state of the s	ou	
ney Transplant (NPA) Kidney Stones Type?		following conditions	1?		
is to any or triese conditions, please provide the dates and specifics of the events, if applicable:					
	or triese conditions, please p	provide the dates an	a specifics of the o	events, it applicable	
iver Function N/A — Please check this box if this category does not apply to you					
Severe Liver Disease (exclusion) Chronic Liver Disease (NPC)	ction N/A Please check	k this box if this category	does not apply to you		
Hepatitis (NPC) Cirrhosis (NPA)			Control of the Contro	Chronic Liver Disea	ase (NPC)
Fatty Liver Disease (NPC) Gallstone	Severe L	iver Disease (exclu	Control of the Contro		ase (NPC)
Please provide dates, if applicable:	Severe Li Hepatitis Fatty Live	iver Disease (exclus (NPC) or Disease (NPC)	Control of the Contro	Cirrhosis (NPA)	ase (NPC)
If other liver conditions, please list:	Severe Li Hepatitis Fatty Live se provide dates, if applicable	iver Disease (exclus (NPC) er Disease (NPC) e:	Control of the Contro	Cirrhosis (NPA)	ase (NPC)
	Severe Li Hepatitis Fatty Live se provide dates, if applicable	iver Disease (exclus (NPC) er Disease (NPC) e:	Control of the Contro	Cirrhosis (NPA)	ase (NPC)
9. Colon Function N/A - Please check this box if this gaterony does not apply to you	Severe Li Hepatitis Fatty Live se provide dates, if applicable er liver conditions, please lis	iver Disease (exclus (NPC) or Disease (NPC) e: t:	sion)	Cirrhosis (NPA) Gallstone	ase (NPC)
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.)?	Severe Li Hepatitis Fatty Live se provide dates, if applicable er liver conditions, please lis	iver Disease (exclusion (NPC) or Disease (NPC) e: t:	sion) this category does not a	Cirrhosis (NPA) Gallstone	ase (NPC)
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	Severe Li Hepatitis Fatty Live se provide dates, if applicable er liver conditions, please lis  bion Function N/A— bu have any bowel issues (IE	iver Disease (exclusion (NPC) or Disease (NPC) e: t:	sion)  his category does not a	Cirrhosis (NPA) Gallstone	ase (NPC)
Do you have any bowel issues (IBS, constipation, diarrhea, etc.)?	Severe Li Hepatitis Fatty Live se provide dates, if applicable er liver conditions, please lis  plon Function N/A — pu have any bowel issues (IE please list)	iver Disease (exclusion (NPC) or Disease (NPC) e: t:	sion)  his category does not a	Cirrhosis (NPA) Gallstone	ase (NPC)

	Acid Reliux and /or Heartburn		Geliac Disease / Gluten intolerar	ice		
	Bariatric Surgery (or history or	f) (NPA)	If surgery, what type?			
11. Endocr	rine Function N/A - Please che	eck this box if this category d	oes not apply to you			
Have you ha	ad or currently have any of the follow					
, 54 114	Thyroid issues (NPA/M)	g conditions:	Adrenal disease			
	Parathyroid issues		Adrenal disease Other:			
If so, please			oner.			
			is category does not apply to you	AND SECURE		
Do you curre	ently have any of the following condi	tions?				
	Irregular periods / Amenorrhea		Hysterectomy			
	Menopause		Polycystic Ovarian Syndrome (PCOS)			
	Pregnant (NPC - OB/GYN)		Breastfeeding (NPC Pediatrician)			
	menstrual cycle:					
	g any contraception?		Yes No Type:	C Marie		
		check this box if this categor	y does not apply to you			
Do you have	any of the following conditions?					
	Alzheimer's disease or dementia (N	NPA)	Epilepsy (NPA) Date of last seizure:			
	Parkinson's disease (NPA)		Other:			
14. Emotion	nal Function N/A - Please che	ck this box if this category do	pes not apply to you			
Oo 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 medicat	tions, i.e. lithium)	Other:			
5. Inflamm	natory Conditions N/A - Plea	ase check this box if this cate	gory does not apply to you			
Oo you have	any of the following conditions?					
	Fibromyalgia		Multiple Sclerosis			
Lupus			Psoriasis			
	Migraines		Rheumatoid			
any, please	specify other autoimmune or inflam	matory conditions:				
6. Cancer	N/A - Please check this box if this car	tegory does not apply to you				
o you currer	ntly have cancer? (NPC & requires					
	ent from by Oncologist)	Yes	No			
so, what typ	pe, local or metastatic?					
s your cance	er in remission?	Yes (NPA)	No			
7. Allergies		The state of the s				
o you have	any of the following conditions?					
Food	allergies	If so, please specify:				
	d intolerances	16 a				
	en Sensitivity	If so, please specify:				
Other Ho		co shook this bay Katalana	and does not easily to	Theres		
	any other health conditions?	se check this box if this categ	Yes No			
so, please s			res No			
	• man of • • • • • • • • • • • • • • • • • •					
9. Drink Co	onsumption					
o you drink a	alcohol? Yes	No				
	d that the consumption of any type	pe of alcohol is strictly	y prohibited while on the Ideal Protei	n		
rotocol.						
	poop of water de la		Initials:			
	asses of water do you drink per day'		glasses per day			
	no of coffee (ff-i		cups per day			
	ps of coffee (or caffeinated tea) do y					
	How much crea	m or milk do you use?	tbsp./packets			
low many cu	How much creat How much sugar or sw	m or milk do you use?	tbsp./packets tsp./packets			
low many cu	How much crea	m or milk do you use?	tbsp./packets			

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:		165	Sometimes	No	
Examples:					
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		ritamins.			
Please refer to the example in the first	line. Number of				
Name of medication Milligrams* per and supplement capsule/tablet	capsules/tablets	Number of per da		octor Reason for taking	
and supprement capsulariables	per day	hei ge	4		

Thyroid issue

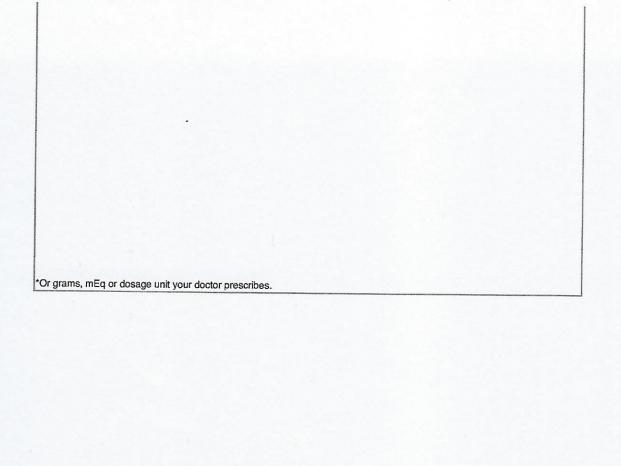
Dr. John Doe

Medication "X"

500 mg

1

Once a day



## 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<sup>TM</sup> 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	(ci	ty/state), on this _	day of		_, 20
lame of witness (pri	nt):				-
lame of client (print)	•				
Client Signature		_	Witness Signature	)	
submitted to bindin	that all claims against an g arbitration under the ru	les of the Arbitratio	n Act or similar stat	choose to mak	e shall only be of residence, and I
waive any rights to	pursue any claims or cau	ises of action in an	y court of law.		
Last name:2	First name:	DOB (DD/MM	VYY):Patient/	Client Initials:	Coach Initials
					Rev April 2020 (119

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