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

Do you have any of the following conditions?

☐ 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.

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