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? _____

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?

- ☐ Arrhythmia (NPA)
- ☐ Blood Clot (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Heart attack (NPC)
- ☐ Heart Valve Problem (NPA)
- ☐ Heart Valve Replacement (porcine/mechanical) (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Hyperkalemia (High potassium) (NPA)
- ☐ Hypokalemia (Low potassium) (NPA)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Stroke or Transient Ischemic Attack (NPA)
- ☐ Congestive Heart Failure (NPC)

Please select one (if applicable):
- ☐ History of Congestive Heart Failure
- ☐ Current Congestive Heart Failure (NPC)

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:

_____

_____

7. Digestive Function ☐ N/A

Do you have any of the following conditions:

- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Gastric Ulcer (NPA)
- ☐ Gluten intolerance
- ☐ Heartburn
- ☐ 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:

- ☐ Amenorrhea
- ☐ Fibrocystic Breasts
- ☐ Heavy periods
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Menopause
- ☐ Painful periods
- ☐ Uterine Fibroma

Date of last menstrual cycle: _____

Are you taking oral contraceptive pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

9. Endocrine Function ☐ N/A

Do 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

10. Neurological/Emotional Function ☐ N/A

Do you have any of the following conditions:

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

Other issues: _____

11. Inflammatory Conditions ☐ N/A

Do you have any of the following conditions:

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

12. Cancer ☐ N/A

Do 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/A

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

14. Allergies ☐ N/A

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please specify: _____

_____

_____

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:

_____

_____

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

Approximate time: _____

Examples:

_____

_____

LUNCH

Do you have lunch every day? ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples:

_____

_____

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

Approximate time: _____

Examples:

_____

_____

_____

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: _____

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: _____

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: _____

QUESTIONNAIRE

This questionnaire is to be used for screening purposes only and is not intended to be used or to act as a diagnostic tool.

Body Image

a) I like my body when I see myself in the mirror.	Always	Sometimes	Never
b) What makes me unhappy about my body?	_____		

Meal Planning

a) I have difficulties shopping for healthy food options.	Always	Sometimes	Never
b) I read labels.	Always	Sometimes	Never
c) I understand labels.	Always	Sometimes	Never
d) I buy foods impulsively while shopping.	Always	Sometimes	Never
e) I am concerned that I will not prepare my meals ahead of time.	Always	Sometimes	Never

Hydration

a) I drink at least 2 liters of water daily.	Always	Sometimes	Never
b) I need flavoring in my water.	Always	Sometimes	Never
c) I remember to drink water during the course of the day.	Always	Sometimes	Never
d) I like drinking water.	Always	Sometimes	Never

Cravings

a) I crave carbohydrates during the day.	Always	Sometimes	Never
b) If always or sometimes, around what time of day.	9:00 am	3:00 pm	8:00 pm
c) I control my cravings.	Always	Sometimes	Never
d) I am preoccupied with food/eating.	Always	Sometimes	Never

Food Journal

a) I intend on using the Phase 1 Daily Journal.	Always	Sometimes	Never	
b) I am afraid it will be hard to follow the Ideal Protein Weight Loss Method.	Always	Sometimes	Never	
c) I consume the largest amount of calories during what time of the day?	9:00 am	3:00 pm	8:00 pm	Other: _____

QUESTIONNAIRE

Emotional Eating

a) When I get emotional, I have a tendency to binge eat.		Always	Sometimes	Never
b) If so, with what kind of food?		_____		
c) I experience the following emotion during the binge.		Happiness	Regret	No emotion
		Other:_____		
d) How long does the emotion usually last?		Short term		Long term
e) I feel guilty after eating.		Always	Sometimes	Never
1. Is there a kind of meal that makes me feel guilty?			Yes	No
2. If so, what kind?		_____		
f) I avoid eating when I am hungry.		Always	Sometimes	Never
g) I eat food in secret.		Always	Sometimes	Never
h) I feel that food replaces something in my life.			Yes	No

Mealtime

a) I sit at the dinner table to eat my meals.		Always	Sometimes	Never
b) I take the time to prepare my meals.		Always	Sometimes	Never
c) I multitask during my meals (TV, work, etc.)		Always	Sometimes	Never
d) The environment in which I eat my meals affects my eating.		Always	Sometimes	Never
e) On average, how long do I take to eat my meals?	< 5 min	5-10 min	10-15 min	>15 min

Smoking

a) I smoke.			Yes	No
b) If yes, I want to stop smoking.			Yes	No
c) How many times have I tried to stop smoking.		< 2	< 4	Over 6

Sleep Habits

a) How many hours a night do I sleep?		_____		
b) I intend to track my sleeping habits in my Daily Journal.		Always	Sometimes	Never

a) I am confident that I will reach my weight loss goal.		Yes	Somewhat	No
b) If unsure, what things make me feel uncertain that I will lose weight?		_____		