

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: _____

Age (NPC, if client is <18 years of age): _____

Date of birth: _____
 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? _____

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

Health Profile

1. Overall (continued)

On average, how many hours do you sleep per night? _____

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: _____ Last visit: _____

Dr. _____ Specialty: _____

Patient since: _____ Last visit: _____

Dr. _____ Specialty: _____

Patient since: _____ Last visit: _____

Dr. _____ Specialty: _____

Patient since: _____ Last visit: _____

2. Diabetes N/A

Do you have Diabetes? Yes No If no, please skip to next section.

Which type? Type I Diabetes (NPC) – Multiple Daily Insulin Injections (MDI) or Insulin Pump

Prediabetes – No Diabetes Medication, or only using Metformin

Type II Diabetes – No Medication

Type II Diabetes – Medications such as Metformin; GLP-1 Agonists; DPP-4 Inhibitors

Type II Diabetes (NPC) – Sodium-Glucose Co-Transporter Inhibitors (SGLT2s)

Type II Diabetes (NPC) – Sulfonylureas, Thiazolidinediones (TZDs).

Type II Diabetes (NPC) – on Insulin

Is your blood sugar level monitored? Yes No If yes, how often? _____

If yes, 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 or Alternative Protocol on these medications. Speak to your coach.

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

Health Profile

3. Cardiovascular Function N/A

Have you had any of the following conditions?

- | | |
|--|--|
| <input type="checkbox"/> Arrhythmia (NPA) | <input type="checkbox"/> Hyperkalemia (High potassium) (NPC) |
| <input type="checkbox"/> Blood Clot (NPC) | <input type="checkbox"/> Hypokalemia (Low potassium) (NPC) |
| <input type="checkbox"/> Coronary Artery Disease (NPA) | <input type="checkbox"/> Hypertension (High blood pressure) (NPC) |
| <input type="checkbox"/> Heart Attack (NPC) | <input type="checkbox"/> Pulmonary Embolism (NPC) |
| <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"/> History of Congestive Heart Failure (NPA) |
| <input type="checkbox"/> Hyperlipidemia
(High cholesterol/triglycerides) | <input type="checkbox"/> Current Congestive Heart Failure (NPC) |

Have you ever had **any** type of heart surgery? Yes (NPA) No

If yes, 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 (NPA). Do you presently have kidney stones? Yes (NPA) No Since when: _____

If yes, what medication has been prescribed? _____

- Gout (NPA). Do you presently have gout? Yes (NPA) No Since when: _____

If yes, what medication has been prescribed? _____

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

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

Health Profile

5. Liver Function N/A

Have you ever had your gallbladder removed Yes No
 If NO, have you ever had **gallstones/gallbladder attack** (NPA)? Yes (NPA) No
 Do you have fatty liver? Yes No
 Do you have **fatty liver with fibrosis or cirrhosis** (NPA)? Yes (NPA) No
 Do you have any **other** liver conditions (NPA)?
 Please specify: _____

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 Gluten intolerance
 Celiac Disease Heartburn
 Gastric Ulcer (NPA) **History of Bariatric Surgery** (NPA)
 Gastroesophageal Reflux Disease (GERD) **If yes, what type of Bariatric Surgery (NPA)?**

8. Ovarian/Breast Function N/A

Do you currently have any of the following conditions?
 Amenorrhea Irregular periods
 Fibrocystic Breasts Menopause
 Heavy periods Painful periods
 Hysterectomy Uterine Fibroma
 PCOS Infertility
 Date of last menstrual cycle: _____
 Are you taking oral contraceptive pills? Yes No
 Are you pregnant? *Not eligible for the Protocol.* Yes No
 Are you breastfeeding? *Not eligible for the Protocol.* Yes No

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



Health Profile

9. Endocrine Function N/A

Do you have thyroid problems? Yes No
 If yes, please specify: _____

Do you have parathyroid problems? Yes No
 If yes, please specify: _____

Do you have adrenal gland problems? Yes No
 If yes, 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?

<input type="checkbox"/> Alzheimer's Disease (NPA)	<input type="checkbox"/> Depression
<input type="checkbox"/> Anorexia (or History of) (NPA)	<input type="checkbox"/> Epilepsy (NPA)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Bipolar Disorder – ON Lithium. <i>Not eligible for the Protocol.</i>	
<input type="checkbox"/> Bipolar Disorder – NOT on Lithium (NPA)	<input type="checkbox"/> Parkinson's Disease (NPC)
<input type="checkbox"/> Bulimia (or History of) (NPA)	<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 (MS) (NPA)
<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	

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



Health Profile

12. Cancer N/A

Do you have cancer (NPC)? Yes (NPC) No

If yes, what type and where is it located? _____

Have you ever had cancer (NPA)? Yes (NPA) No

If yes, what type and where is it located? _____

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

If yes, how long have you been in remission? _____ (mm/yy)

13. General N/A

Do you have any other health problems? Yes No

If yes, please specify: _____

Any other surgeries? Yes No

If yes, please specify: _____

14. Allergies N/A

Do you have any food allergies or sensitivities? Yes No

If yes, please specify: _____

15. Eating Habits

Please provide honest answers to the following questions so that we can help you.

BREAKFAST

Do you have breakfast every morning? Always Most days Rarely Never

Approximate time: _____

Examples:

Do you have a snack before lunch? Always Most days Rarely Never

Approximate time: _____

Examples:

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

Health Profile

15. Eating Habits (continued)**LUNCH**Do you have lunch every day? Always Most days Rarely Never

Approximate time: _____

Examples:

_____Do you have a snack before dinner? Always Most days Rarely Never

Approximate time: _____

Examples:

_____**DINNER**Do you have dinner every day? Always Most days Rarely Never

Approximate time: _____

Examples:

_____Do you have a snack at night? Always Most days Rarely Never

Approximate time: _____

Examples:

_____**OTHER**Are you a vegan? Yes No*Not eligible for the Protocol. Strict vegans do not qualify due to too many dietary restrictions.*Are you a vegetarian? Yes NoDo you smoke? Yes No

If yes, what do you smoke? _____ How many per day? _____

For how many years? _____

Do you drink alcoholic beverages? Yes No

If yes, 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: _____

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: _____