Health Profile

1. General Date:_____/_____/_____

Dietary consultation involves a health profile which purpose 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.

(Please Print)
Last Name: _____First Name_____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip Code:_____

Cell: _____ Phone: _____ Profession:_____

Email:_____@_____

Date of Birth:_____/_____/_____ Age:_____

Who may we thank for referring you?_____

Current Weight: _____lbs. Height: _____ Weight 1 year ago: _____ lbs.

Minimum adult weight: _____lbs. at age _____ Maximum adult weight: _____ lbs.

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 (e.g. too rigid, too much cooking involved, etc.):
_____
_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's professionally supervised weight loss method: (circle one)

Least important 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Very/Most Important

What is your marital status? M S D W Other Do you have children? ☐ Yes ☐ No
How many children do you have? _____ How old are your children? _____
Who does most of the cooking in your house? _____
On average, how many hours do you sleep per night?_____

Who is your primary care physician (family doctor)? _____
Physician List:
Please list any physicians you see and their specialty:

mo/yr
Dr. _____Specialty: _____ Patient since: ____/____

Dr. _____Specialty: _____ Patient since: ____/____

Dr. _____Specialty: _____ Patient since: ____/____

Dr. _____Specialty: _____ Patient since: ____/____

2. Diabetes:
Do you have diabetes? ☐ Yes ☐ No (If not, please skip to next section)

Which type?
B.☐ Type I - Insulin-dependent (insulin injections only)
B.☐ Type II - Non-insulin-dependent (diabetic pills)
C.☐ 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

3. Cardiovascular Function:

Have you had any of the following cardiovascular conditions?
a. ☐ Heart Attack (NPC) b. ☐ Blood Clot (NPA) c. ☐ Pulmonary Embolism (NPA)
d. ☐ Stroke or TIA (NPA) e. ☐ Coronary Artery Disease (NPA) f. ☐ Heart Valve (NPA)
g. ☐ Heart Valve Replacement – porcine / mechanical (NPA)
h. ☐ Arrhythmia (NPA- if on Rx medications) i. ☐ Hypertension (High blood pressure) (NPA)
j. ☐ Hypokalemia (Low Potassium) (NPA) k. ☐ Hyperkalemia (High Potassium) (NPA)
l. ☐ Hyperlipidemia (High Cholesterol/Triglycerides) m. ☐ Congestive Heart Failure (NPC)
Please select one (if applicable): ☐ History of Congestive Heart Failure (NPA)
☐ Current Congestive Heart Failure (NPC)
Have you ever had ANY type of heart surgery? ☐ Yes or ☐ No
If so, which type?
_____

Other Conditions:_____

If you have answered yes to any of these conditions, please give dates of occurrence. For multiple conditions, please specify: _____

_____ _____

_____ _____

4. Kidney Function:

Have you had: mo/yr

a. Kidney Stones ☐ Yes ☐ No ___/____ b. Kidney Disease (NPA) ☐ Yes ☐ No ___/____

c. Kidney Transplant(NPA) ☐ Yes ☐ No ___/____

d. Did you ever have Gout? ☐ Yes ☐ No ___/___

If so, what medication was prescribed? _____

Do you have Gout? ☐ Yes ☐ No If so since when? ___/____

5. Liver Function:

Have you had any liver issues? (NPA) ☐ Yes ☐ No ___/___

If yes, please list:

_____ _____

6. Colon Function:

Do you have:

a. Irritable Bowel Syndrome ☐ Yes ☐ No b. Diverticulitis ☐ Yes ☐No

c. Ulcerative Colitis ☐ Yes ☐ No e. Crohn's Disease ☐ Yes ☐ No

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

_____ _____

_____ _____

7. Digestive Function:

Do you have:

a. Acid Reflux ☐ Yes ☐ No b. Heartburn ☐ Yes ☐ No c. Gastric Ulcer (NPA) ☐ Yes ☐ No

d. Are you Gluten intolerant? ☐ Yes ☐ No e. Celiac Disease ☐ Yes ☐ No

f. History of Bariatric surgery? (NPA) ☐ Yes ☐ No ___/___

If so what type of bariatric surgery? _____

8. Ovarian/Breast Function:

Please check the situations that apply to you **currently**:

a. Fibrocystic Breasts ☐ Yes ☐ No b. Hysterectomy ☐ Yes ☐ No

c. Amenorrhea ☐ Yes ☐ No d. Menopause ☐ Yes ☐ No e. Uterine Fibroma ☐ Yes ☐ No

f. Irregular Periods ☐ Yes ☐ No g. Painful Periods ☐ Yes ☐ No h. Heavy Periods ☐ Yes ☐

Date of last menstrual cycle: ____/____/____/

Are you on oral birth control pills? ☐ Yes ☐ No
i. Are you pregnant? ☐ Yes ☐ No j. Are you breastfeeding? ☐ Yes ☐ No

9. Endocrine Function:

a .Do you have thyroid problems? ☐ Yes ☐ No If so, please specify: _____
b. Do you have parathyroid problems? ☐ Yes ☐ No If so, please specify: _____
c. Do you have adrenal gland problems? ☐ Yes ☐ No If so, please specify:_____

Have you been told you have Metabolic Syndrome (also called "Syndrome X")? ☐ Yes ☐ No

10. Neurological/Emotional Function:

Do any of the following apply to you?
a. Bipolar Disorder ☐ Yes ☐ No b. Panic Attacks ☐ Yes ☐ No c. Depression ☐ Yes ☐ No
d. Epilepsy(NPA) ☐ Yes ☐ No e. Anorexia (History of) ☐ Yes ☐ No
f. Parkinson's disease ☐ Yes ☐ No g. Schizophrenia ☐ Yes ☐ No
h. Bulimia (History of) ☐ Yes ☐ No i. Alzheimer's disease ☐ Yes ☐ No
Other issues: _____

11. Inflammatory Conditions:

Do any of the following apply to you?
a. ☐ Migraines b. ☐ Fibromyalgia c. ☐ Rheumatoid d. ☐ Lupus e.☐ Psoriasis
f. ☐ Chronic Fatigue Syndrome g. ☐ Multiple Sclerosis h. ☐ Osteoarthritis
i. ☐ Other autoimmune or inflammatory condition _____

12. Cancer:

a. Do you have Cancer? (NPC) ☐ Yes ☐ No If so, what type and where is it located? _____
_____
b. Have you ever had Cancer? (NPC) ☐ Yes ☐ No If so, what type and where was it located?
_____
When was the Cancer diagnosed? ____/____/____
c. Is your Cancer in remission? (NPC) ☐ Yes ☐ No If so, since ___/___

13. General:

Do you have any other health problems? ☐ Yes ☐ No If so, please specify:_____
_____

14. Allergies:

Do you have any food allergies or sensitivities? ☐ Yes ☐ No If so, please list:

_____ _____

_____ _____

15. Eating Habits
(Please be as honest as possible so that we may better help you)

Breakfast
Do you have breakfast every morning? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Do you have a snack before lunch? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Lunch
Do you have lunch every day? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Do you have a snack before dinner? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Dinner
Do you have dinner every day? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Do you have a snack at night? ☐ Yes ☐ Sometimes ☐ Never
Approximate time:_____
Examples:

_____

Are you a vegan? ☐ Yes ☐ No (Strict Vegans may not qualify because of dietary restrictions)
Are you a vegetarian? ☐ Yes ☐ No

How many cups of <u>water</u> do you drink per day? _____
How many cups of coffee do you drink per day? _____
How many cups of sodas (any kind) do you drink per day? _____

Do you smoke? ☐ Yes ☐ No If so how many packs a day ____ If so for how many years?___
Do you drink alcohol ☐ Yes ☐ No If so, what and how often?

_____

16. Medications

Dear Client: Please complete this form by listing all prescription medications and supplements that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet?*	How many tablets do you take each day	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500 mg	1	1 x a day	Dr. John Doe	Iron deficiency

* 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 provide and that is recorded by me on this Ideal Protein[tm] 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 blue and or underlined / identified as NPC or NPA on this form. Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein[tm] Weight Loss Method if I have any of the said conditions or if I am currently talking any of the said medications unless i) I specifically consult with a medical doctor concerning my suitability to go on the Ideal Protein[tm] Weight loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein[tm] Weight Loss Method, and iii) and 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 go on the Ideal Protein[tm] Weight Loss Method without specific supervision, such decision will be completely voluntary, and I release and discharge the clinic as well as Ideal Protein of America Inc., its parent companies, subsidiaries and affiliates and 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.

I confirm that the Ideal Protein[tm] Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein[tm] Weight Loss Method, that I have been provided with the answers to such questions and that I understand the importance of strictly following the ideal method 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[tm] Weight Loss Method.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein Weight Loss Method limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein[tm] Weight Loss Method.

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 on the Ideal Protein[tm] Weight Loss Method.

I specifically agree that all claims against any of the Releases that I may have or choose to make shall only be submitted to binding arbitration under the rules and guidelines of the American Arbitration Association, and I waive any rights to pursue any claims or causes of action in any court of law.

SIGNED IN Corpus Christi, Texas, on this _____ day of _____, 20____

_____ _____

Witness Sign Client Sign

Name of Witness (print):_____ Name of client:_____

_____ Initials

Ideal Weightloss Medical Clinic

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I hereby give my consent for Ideal Weightloss Medical Clinic to use and disclose protected health information about me to my Primary Physician(s) or Health care provider(s)

This protected Health information may only be used by the authorized personal for my medical treatment, consultation, or other purposes as I may direct.

I have the right to at anytime revoke my consent in writing except to the extent that Ideal Weightloss Medical Clinic has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to allow Ideal Weightloss Medical Clinic to use and disclose my protected health information to my physician(s) or healthcare provider(s).

_____
Signature of Patient

_____ _____
Print Patient's Name Date

Release for Use of Images

I do hereby grant Ideal Clinic Inc. the "Grantee" an irrevocable, unrestricted, royalty-free right and license to use, reproduce, display, adapt, modify and/or distribute, my name and likeness, including, without limitation "before" and "after" photographs, and any testimonials provided by me with respect to Ideal Weightloss Medical Clinic, in all forms and media (including via the Internet) and in all manners, for Grantee's marketing and promotional efforts and all other lawful purposes. I waive any right to inspect or approve the finished versions, including written copy that may be created in connection therewith. I understand that I will not be paid at any time for the use of any images, information or other media provided by me, and no representation to the contrary has been made to me.
I have read this release and am fully familiar with its contents.

Signature: _____ Date: _____

Please Print Name_____