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: _____ Province: _____ Postal 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 weight loss method: (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)
Dr.	_____	Specialty:	_____	Patient since:	_____	(MM/YY)
Dr.	_____	Specialty:	_____	Patient since:	_____	(MM/YY)
Dr.	_____	Specialty:	_____	Patient since:	_____	(MM/YY)
Dr.	_____	Specialty:	_____	Patient since:	_____	(MM/YY)

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 a Sodium-Glucose Co-Transporter inhibitor (SGLT-2), do not start the weight loss method.

3. Cardiovascular Function ☐ N/A

Have you had any of the following conditions?

- ☐ Arrhythmia (NPA - if not on Rx medication)
- ☐ 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)

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
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable Bowel Syndrome
- ☐ 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? _____

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

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
If so, please specify: _____		

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

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 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 purple / 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 taking 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) 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 center 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 center as well as Laboratoires C.O.P. Inc., its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "**Releases**") 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 Protein[tm] Weight Loss 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[tm] 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 center 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 of the Arbitration Act or similar statute of my province of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

Signed in _____ (city/province), on this _____ day of _____, 20_____.

Name of witness: _____

Name of client (print) _____

_____ _____

Name and title Signature

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