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.

Overall (Please use print characters)

First name: ____________ Last name: ____________

Address: ____________ Apt. /unit: ______

City: ____________ Province: ______ Postal code: ____________

Phone: ____________ Cell: ____________

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 ☐ Other ☐ Divorce ☐ Widow

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? ________

Last name: ____________ First name: ____________ DOB: ________ (DD/MM/YY) Initials ______

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)
Dr. ______________________ Specialty: ______________ Patient since: ________ (MM/YY)

Diabetes

Do you have diabetes? ☐ Yes ☐ No If not, 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.

Cardiovascular Function

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:

Last name: ______________ First name: ______________ DOB: __________ (DD/MM/YY) Initials ______

Kidney Function

Have you had any of the following conditions:

- ☐ Kidney Disease (NPA) — Date: ____________
- ☐ Kidney Transplant (NPA)
- ☐ Kidney Stones — Date: ____________
- ☐ Do you have Gout? ☐ Yes ☐ No If so, since when? ______

If so, what medication has been prescribed?

If no, have you ever had Gout? ☐ Yes ☐ No If so, since when? ______

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

Liver Function

Have you ever had any liver conditions? ☐ Yes ☐ No Date: ____________

If yes, please list: ________________________________

Colon Function

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 events, please give dates of events. For multiple events please specify:

Digestive Function

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 ______

Ovarian/Breast Function

Do you currently have any of the following conditions:

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

Ovarian/Breast Function (continued)

Date of last menstrual cycle: ____________________

Are you on oral contraceptive pills?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No

Endocrine Function

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

Neurological/Emotional Function

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: ________________________________

Last name: ____________________ First name: ____________________ DOB: ____________ (DD/MM/YY) Initials ______

Inflammatory Conditions

Do you have any of the following conditions:

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

Cancer

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 was it located? ☐ Yes ☐ No

Is your cancer in remissions? (NPC) ☐ Yes ☐ No

If so, how long have you been in remission? __________ (MM/YY)

General

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

If so, please specify: ____________________

Allergies

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

If so, please specify: ____________________

Last name: ____________________ First name: ____________________ DOB: ____________ (DD/MM/YY) Initials ______

Eating Habits

(Please provide honest answers so that we can help you)

BREAKFAST

Do you have breakfast every morning? ☐ Yes ☐ No ☐ Never

Approximate time: ____________

Examples: ______________________________________

____

____

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

Approximate time: ____________

Examples: ______________________________________

____

____

LUNCH

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

Approximate time: ____________

Examples:

____

____

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

Approximate time: ____________

Examples:

____

____

DINNER

Do you have dinner every day? ☐ Yes ☐ No ☐ Never

Approximate time: ____________

Examples: ______________________________________

____

Do you have a snack at night? ☐ Yes ☐ No ☐ Never

Approximate time: ____________

Examples: ______________________________________

____

____

Last name: ____________________ First name: ____________________ DOB: ____________ (DD/MM/YY) Initials ______

OTHER				
Are you a vegan?	☐	Yes	☐	No
Strict vegans do not qualify due to too many dietary restrictions.				
Are you a vegetarian?	☐	Yes	☐	No
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		
Do you **smoke**?	☐	Yes	☐	No
If so, how many packs per day? ______ for how many years?				
Do you drink alcohol?	☐	Yes	☐	No
If so, what and how often? __________				

Last name: ___________________ First name: ___________________ DOB: ____________ (DD/MM/YY) Initials ______

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 or blue / 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 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 "**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 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 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 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