



Health Profile

Dietary consultation involves a health profile whose purpose is not to establish a diagnosis, but rather to determine a client's health status in order to guide his or her weightloss plan. A client may be advised to seek medical advice based on his or her health profile.

General

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Date of Birth: _____ Age: _____ Profession: _____

Whom may we thank for referring you? _____

Weight: _____ lbs. Weight 1 year ago: _____ lbs. Min. Adult Weight: _____ lbs at age _____ Maximum

Weight: _____ lbs. at age _____ Height: _____

Do you exercise? Yes No If yes, what kind?

How often? _____

Have you been on a diet before? Yes No _____ If yes, please specify which diet 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 medically supervised weight loss method (10 being the most important):

Family Life:

What is your marital status? M S D W Do you have children? Yes No Number of children: _____ Ages: _____

Medical Information:

Please list any physicians you see and their specialty:

Diabetes:

Do you have diabetes? Yes No (if no, skip to next section) If so, are you under the care of a physician? Yes No If so, which type?

Type I – insulin dependent (insulin injections only)

Type II – noninsulin dependent (diabetic pills)

Type II – insulin dependent (diabetic pills and insulin) Is your blood sugar level monitored? Yes No If so, by whom? Myself Physician Other (specify):

Are you taking any medication? Yes No If so, please list:

Do you tend to be hypoglycemic? Yes No

Cardiovascular Health:

Have you had a cardiovascular event? Yes No (if no, skip to next section) If so, please specify:

How long ago?

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Do you have a history of arrhythmia Yes No

Hypertension:

Do you have high blood pressure? If so, do you have your blood pressure checked? If so, are you under the care of a physician? Are you taking any medication?

Yes
Yes Yes No (if no, skip to next section)
 Yes No No No

If so, please list:

Kidney Health:

Have you been diagnosed with kidney disease? Yes No (if no, skip to next section) If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Have you ever had Gout? Yes No

Liver Health:

Do you have liver problems? Yes No (if no, skip to next section) If so, please specify:

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Colon Health:

Do you have: Irritable Bowel Colitis Diarrhea Diverticulosis?
 Crohn's disease Constipation If so, are you under the care of a physician? Yes
 No Are you taking any medication? Yes No If so, please list:

Stomach/Digestive Health:

Do you have: Acid Reflux Gastric Ulcer Heartburn Celiac Disease? If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Ovarian/Breast Health:

Check off the situations that apply to you currently:

Irregular Periods Menopause Fibrocystic Breasts
 Painful Periods Hysterectomy Heavy periods
 Amenorrhea Uterine fibroma Cancer (uterus, breast) If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Please indicate the date of your last menstrual cycle:

Thyroid Function:

Do you have thyroid problems? Yes No (if no, skip to next section) If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Emotional Evaluation:

Do any of the following apply to you? (if no, skip to next section)

- Depression Anxiety Panic Attacks
- Bulimia (or history of) Anorexia (or history of) If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Inflammatory Conditions:

Do any of the following apply to you? (if no, skip to next section)

- Migraines Fibromyalgia Rheumatoid Arthritis Lupus
- Osteoarthritis
- Chronic Fatigue Syndrome Psoriasis
- Other autoimmune or inflammatory condition:

If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

General:

Do you have cancer? Yes No

Are you in cancer remission? Yes No If so, please specify and indicate for how long:

_____ If so, are you under the care of a physician? Yes No Are you taking any medication? Yes No If so, please list:

Are you generally fatigued or have low energy? Yes No

Are you pregnant? Yes No Are you breastfeeding? Yes No

Do you get cold easily? Yes No Do you have cold hands/feet? Yes No

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

_____ If so, are you under the care of a physician? Yes No Are you taking any other medications not listed above? Yes No If so, please list: _____ Are you currently taking Vitamins, Herbs or Supplements? Yes No

Vitamin, Herb or Supplement Name Reason

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies:

Do you have any **food** allergies? Yes No If so, please list:

Do you have any **medication** allergies? Yes No If so, please list:

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 eat a **snack** at night? Yes Sometimes Never Approximate Time: _____ Examples: _____

Other:

Do you prefer: Sweet foods Salty foods Fatty foods Are you a vegetarian? Yes No How many glasses of water do you drink per day? _____ glasses How many cups of coffee do you drink per day? _____ cups Do you smoke? Yes No If yes, how many packs per day? _____ for how many yrs? _____ Do you drink alcohol? Yes No If yes, what, how much, and how often? _____

CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger

Score each item on a 0—10 numbering scale. Each feeling represents a different part of the brain and different neurotransmitters

Compulsions/Cravings

Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

012345678910 Never occurs Constant

Appetite

Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

012345678910 Never eat more Always eat more

Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

012345678910 Leave food on plate one plate only second's thirds

Hunger

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

012—3—4—5—6—7—8—9—10 Never hungry Constant hunger

You must take vitamins and minerals while you are on the Ideal Protein WeightLoss Method. If you stop taking them, you may experience undesirable side effects. _____
(Client's initials)

If you are taking medications, are you interested in getting off of any or all of your prescription medications? Yes No

If you have health problems not indicated on this health profile, please consult your physician.

Signature: _____ Date: _____

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.

The client hereby understands that they are enlisting the services of this Ideal Protein Weight Loss clinic to obtain assistance in with weight loss goals and the cost to do so is included in today's total charges in the form of a Nonrefundable Intake Fee in the amount of \$150.00. _____

(Client's Initials)

Contraindication Summary

- Severe Kidney Disease
- Severe Liver Disease
- Congestive Heart Failure
- Active Cancer (or in remission for less than 3 yrs-waived with oncologist auth.)
- Cardiac/Cardiovascular Event (within the last 6 months)
- History of unstable Arrhythmia
- Parkinson's Disease