



Health Profile

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.

General

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ E-mail: _____

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 professionally supervised weight loss method (10 being the most important):

Family Life:

What is your marital status? M S D W Other 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 – non-insulin 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 Function:

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

Have you been diagnosed with Congestive Heart Failure (CHF) Yes No

Hypertension:

Do you have high blood pressure? Yes No (if no, skip to next section)

If so, do you have your blood pressure checked? Yes No

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Kidney Function:

Have you been diagnosed with kidney disease? Yes No
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 Kidney Stones? Yes No

Have you ever had Gout? Yes No

Liver Function:

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 Function:

Do you have: Irritable Bowel Colitis Diarrhea Diverticulitis
 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 Function:

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 Function:

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 Parkinson's disease? Yes No
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:

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

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.

***Disclaimer:**

A history of **Congestive Heart Failure (CHF), Atrial Fibrillation, Parkinson's disease** or **Lithium prescription** are **ABSOLUTE CONTRAINDICATIONS** to the Ideal Protein Weight Loss Method, regular or alternative. No non-medical Ideal Protein Clinic may ever accept such a person as a dieter. The only exceptions are **licensed medical doctors** (MD or DO). These practitioners may accept such patients, if in their professional judgment our protocol would be a benefit to their health. By accepting such a dieter, the physician will assume all responsibility for this patient's health as per their medical license.

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