



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: _____ State: _____ Zip 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 protocol: (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? _____

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



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)	Last visit: _____
Dr. _____	Specialty: _____
Patient since: _____ (MM/YY)	Last visit: _____
Dr. _____	Specialty: _____
Patient since: _____ (MM/YY)	Last visit: _____
Dr. _____	Specialty: _____
Patient since: _____ (MM/YY)	Last visit: _____

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 Sodium-Glucose Co-Transporter inhibitor medication (SGLT-2), which include Ebymect, Edistride, Forxiga, Invokana, Jardiance, Synjardy, Vokanamet and Xigduo, **YOU CANNOT START OR BE ON IDEAL PROTEIN'S REGULAR PROTOCOL.** Please speak to your coach about our Alternative Protocol.

3. Cardiovascular Function N/A

Have you had any of the following conditions?

<input type="checkbox"/> Arrhythmia (NPA)	<input type="checkbox"/> Hyperkalemia (High potassium) (NPA)
<input type="checkbox"/> Blood Clot (NPA)	<input type="checkbox"/> Hypokalemia (Low potassium) (NPA)
<input type="checkbox"/> Coronary Artery Disease (NPA)	<input type="checkbox"/> Hypertension (High blood pressure) (NPA)
<input type="checkbox"/> Heart attack (NPC)	<input type="checkbox"/> Pulmonary Embolism (NPA)
<input type="checkbox"/> Heart Valve Problem (NPA)	<input type="checkbox"/> Stroke or Transient Ischemic Attack (NPA)
<input type="checkbox"/> Heart Valve Replacement (porcine/mechanical) (NPA)	<input type="checkbox"/> Congestive Heart Failure (NPC)
<input type="checkbox"/> Hyperlipidemia (High cholesterol/triglycerides)	<input type="checkbox"/> Please select one (if applicable):
	<input type="checkbox"/> History of Congestive Heart Failure
	<input type="checkbox"/> Current Congestive Heart Failure (NPC)

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3. Cardiovascular Function (cont.) N/A

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

Diverticulitis

Crohn's Disease

Irritable Bowel Syndrome

Diarrhea

Ulcerative Colitis

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

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



7. Digestive Function N/A

Do you have any of the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Gluten intolerance |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Gastric Ulcer (NPA) | <input type="checkbox"/> History of Bariatric Surgery (NPA) |

If so, what type of bariatric surgery? _____

8. Ovarian/Breast Function N/A

Do you currently have any of the following conditions:

- | | |
|--|--|
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Uterine Fibroma |

Date of last menstrual cycle: _____

- | | | |
|--|------------------------------|-----------------------------|
| Are you taking oral contraceptive pills? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you breastfeeding? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

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



10. Neurological/Emotional Function N/A

Do you have any of the following conditions:

- | | |
|--|--|
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anorexia (History of) | <input type="checkbox"/> Epilepsy (NPA) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Bulimia (History of) | <input type="checkbox"/> Schizophrenia |

Other issues: _____

11. Inflammatory Conditions N/A

Do you have any of the following conditions:

- | | |
|---|---|
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Other autoimmune or inflammatory condition | |

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: _____

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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:

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

The Protocol



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

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 to my Ideal Protein™ Protocol service provider (the "Clinic") and that is recorded by me on this Ideal Protein™ 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™ Protocol 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™ Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Protocol, 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 Clinic and iii) nevertheless chose to follow on the Ideal Protein™ Protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Clinic as well as Ideal Protein of America Inc., their parent companies, subsidiaries and affiliates and each of 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 of following the Ideal Protein™ Protocol.

I confirm that the Ideal Protein™ Protocol has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein™ Protocol, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein™ Protocol 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™ Protocol.

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

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 following the Ideal Protein™ Protocol.

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 state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

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

Name of witness (print): _____

Name of client (print) _____

Client Signature

Witness Signature

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



COSTS VS. VALUE

The Ideal Protein Weight Loss Method

The cost of Ideal Protein's comprehensive Weight Loss Method is integrated into each box of food. The value of what you receive in return for your investment in losing weight and improving your health goes considerably beyond the consumption of highly bioavailable, protein-based foods made from quality ingredients.

As an Ideal Protein Dieter at our clinic, among the most significant benefits you'll experience as you progress through the four phases of the method are:

- **Weekly one-on-one coaching and ongoing education by an Ideal Protein certified coach;**
- **A program combining proprietary products that have been shown to lower inflammation*;**
- **Exceptional tasting food selections of the highest quality available;**
- **Daily, phase-specific educational videos designed to inspire your weight loss journey;**
- **Exclusive access to a series of cooking videos featuring delicious, easy-to-prepare meal recipes and ideas created and presented by Ideal Protein's resident Chef Verati;**
- **Supervision of your progress on the method by a licensed healthcare provider;**
- **The option to have your progressive results shared with your primary care provider and/or other specialists;**
- **Access to a proprietary web portal (my.idealprotein.com) with an abundance of tools and educational guidance to support your successful journey;**
- **Continued coaching after weight loss as part of The Ideal Lifestyle Approach to Maintenance. This is a two-tiered approach with a structured 12-month stabilization period followed by maintenance to help sustain weight loss and make appropriate changes.**

Coach initials _____

Dieter initials _____

*Aspirus & Avera Cancer Institute Studies, 2014

QUESTIONNAIRE

This questionnaire is to be used for screening purposes only and is not intended to be used or to act as a diagnostic tool.

Body Image

- | | | | |
|--|--------|-----------|-------|
| a) I like my body when I see myself in the mirror. | Always | Sometimes | Never |
| b) What makes me unhappy about my body? | _____ | | |

Meal Planning

- | | | | |
|---|--------|-----------|-------|
| a) I have difficulties shopping for healthy food options. | Always | Sometimes | Never |
| b) I read labels. | Always | Sometimes | Never |
| c) I understand labels. | Always | Sometimes | Never |
| d) I buy foods impulsively while shopping. | Always | Sometimes | Never |
| e) I am concerned that I will not prepare my meals ahead of time. | Always | Sometimes | Never |

Hydration

- | | | | |
|--|--------|-----------|-------|
| a) I drink at least 2 liters of water daily. | Always | Sometimes | Never |
| b) I need flavoring in my water. | Always | Sometimes | Never |
| c) I remember to drink water during the course of the day. | Always | Sometimes | Never |
| d) I like drinking water. | Always | Sometimes | Never |

Cravings

- | | | | |
|---|---------|-----------|---------|
| a) I crave carbohydrates during the day. | Always | Sometimes | Never |
| b) If always or sometimes, around what time of day. | 9:00 am | 3:00 pm | 8:00 pm |
| c) I control my cravings. | Always | Sometimes | Never |
| d) I am preoccupied with food/eating. | Always | Sometimes | Never |

Food Journal

- | | | | | |
|--|---------|-----------|---------|--------------|
| a) I intend on using the Phase 1 Daily Journal. | Always | Sometimes | Never | |
| b) I am afraid it will be hard to follow the Ideal Protein Weight Loss Method. | Always | Sometimes | Never | |
| c) I consume the largest amount of calories during what time of the day? | 9:00 am | 3:00 pm | 8:00 pm | Other: _____ |

QUESTIONNAIRE

Emotional Eating

a) When I get emotional, I have a tendency to binge eat.

Always Sometimes Never

b) If so, with what kind of food?

c) I experience the following emotion during the binge.

Happiness Regret No emotion
Other: _____

d) How long does the emotion usually last?

Short term Long term

e) I feel guilty after eating.

Always Sometimes Never

1. Is there a kind of meal that makes me feel guilty?

Yes No

2. If so, what kind?

f) I avoid eating when I am hungry.

Always Sometimes Never

g) I eat food in secret.

Always Sometimes Never

h) I feel that food replaces something in my life.

Yes No

Mealtime

a) I sit at the dinner table to eat my meals.

Always Sometimes Never

b) I take the time to prepare my meals.

Always Sometimes Never

c) I multitask during my meals (TV, work, etc.)

Always Sometimes Never

d) The environment in which I eat my meals affects my eating.

Always Sometimes Never

e) On average, how long do I take to eat my meals?

< 5 min 5-10 min 10-15 min >15 min

Smoking

a) I smoke.

Yes No

b) If yes, I want to stop smoking.

Yes No

c) How many times have I tried to stop smoking.

< 2 < 4 Over 6

Sleep Habits

a) How many hours a night do I sleep?

b) I intend to track my sleeping habits in my Daily Journal.

Always Sometimes Never

a) I am confident that I will reach my weight loss goal.

Yes Somewhat No

b) If unsure, what things make me feel uncertain that I will lose weight?