



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? _____

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)
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?

<input type="checkbox"/> Arrhythmia (NPA - if not on Rx medication)	<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)
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever had **any** type of heart surgery? _____
 If so, which type? _____

Other conditions: _____

If you have answered yes to any of the above conditions, please give **all** dates of occurrence:

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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:

- | | |
|--|---|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> 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:

- | | |
|--|---|
| <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? _____

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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? 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:

- | | |
|--|--|
| <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: _____

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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: _____

14. Allergies N/A

Do you have any food allergies or sensitivities? Yes No

If so, please specify: _____

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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:

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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

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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.

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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™ 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™ 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™ Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ 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™ 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™ Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein™ 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™ 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™ Weight Loss Method.

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein™ 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™ 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™ 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

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