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. **PLEASE ASK YOUR PRIMARY CARE PHYSICIAN TO EMAIL (ORDERPFR@GMAIL.COM) OR FAX (236-4469) RECENT LAB RESULTS (BLOOD GLUCOSE, CHOLESTEROL AND BLOOD PRESSURE). PLEASE CHECK IF COMPLETED____**

1. General:

(Please use print characters)

Last Name: _____ First Name: _____

Insurance Co. _____Group Number._____ Policy Number_____

Address: _____Apt/Unit: # _____

Parish: _____ Postal Code: _____

Phone: _____ Cell: _____ Email: _____@_____

Date of Birth: _____/_____/_____/**Age:** _____ * **Gender**_____

Profession: _____Employer: _____Who may we thank for referring you?_____

Current Weight: _____ lbs. Height: _____ Weight 1 year ago: _____ lbs. Dress size___

Min adult weight: _____lbs. at age _____ Max. adult weight: _____ lbs. Goal Weight: ___

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 (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: (circle one)

Least important **1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** **Very/Most Important**

What is your marital status? M S D W Other Do you have children? ☐ Yes ☐ No

How many children do you have? _____ How old are your children? _____

Who does most of the cooking in your house? _____On average, how many hours do you sleep per night? ____

Physician List:

Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

Dr. _____ Specialty: _____ Patient since: ____/____ (mo/yr)

2. Diabetes:

Do you have diabetes? ☐ Yes ☐ No (If not, please skip to next section)

Which type?

a.☐ **Type I** **- Insulin-dependent (insulin injections only)**

b.☐ Type II - Non-insulin-dependent (diabetic pills)

c.☐ Type II - Insulin-dependent (diabetic pills and insulin)

Is your blood sugar level monitored ☐ Yes ☐ LAST READING OF BLOOD SUGAR: _____

If so, by whom? ☐ Myself ☐ Physician ☐ Other (Please specify): _____

Do you tend to be hypoglycemic? ☐Yes ☐ No

3. Cardiovascular Function: LAST BLOOD PRESSURE READING:____/_____

Have you had any of the following cardiovascular conditions?

a. ☐ Heart Attack (NPC)
b. ☐ Blood Clot (NPA)
c. ☐ Pulmonary Embolism (NPA)
d. ☐ Stroke or TIA (NPA)
e. ☐ Coronary Artery Disease (NPA)
f. ☐ Heart Valve Problem (NPA)
g. ☐ Heart Valve Replacement – porcine / mechanical (NPA)
h. ☐ Arrhythmia (NPA - if on Rx medications)
i. ☐ Hypertension (High blood pressure) (NPA)
j. ☐ Hyperlipidemia (High cholesterol/triglycerides)
k. ☐ Hypokalemia (Low Potassium) (NPA)
l. ☐ Hyperkalemia (High Potassium) (NPA)
m. ☐ 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 these conditions, please give dates of occurrence. For multiple conditions, please specify:

_____ _____
_____ _____
_____ _____

4. Kidney Function:

Have you had:
a. Kidney Stones ☐ Yes ☐ No Date: ____/____/ c. Kidney Disease (NPA) ☐ Yes ☐ No Date: ____/____/
b. Kidney Transplant (NPA) ☐ Yes ☐ No

d. 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, when? ____/____/

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

_____ _____
_____ _____
_____ _____

5 Liver Function:

a. Have you had any liver issues? (NPA) ☐ Yes ☐ No Date: ____/____/

If yes, please list:

_____ _____

_____ _____

6. Colon Function:

Do you have:

a. Irritable Bowel Syndrome	☐ Yes ☐ No	d. Ulcerative Colitis	☐ Yes ☐ No
b. Diverticulitis	☐ Yes ☐ No	e. Crohn's Disease	☐ Yes ☐ No
c. Constipation	☐ Yes ☐ No	f. Diarrhea	☐ Yes ☐ No

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

_____ _____

_____ _____

_____ _____

7. Digestive Function:

Do you have:

a. Acid Reflux	☐ Yes ☐ No	e. Gastric Ulcer (NPA)	☐ Yes ☐ No
b. Heartburn	☐ Yes ☐ No	f. Celiac Disease	☐ Yes ☐ No
c. Are you Gluten intolerant?	☐ Yes ☐ No		

d. History of Bariatric Surgery (NPA) ☐ Yes ☐ No

If so, what type of bariatric surgery? _____

8 Ovarian/Breast Function:

Please check the situations that apply to you currently:

a. Irregular Periods	☐ Yes ☐ No	e. Menopause	☐ Yes ☐ No
b. Fibrocystic Breasts	☐ Yes ☐ No	f. Painful Periods	☐ Yes ☐ No
c. Hysterectomy	☐ Yes ☐ No	g. Heavy Periods	☐ Yes ☐ No
d. Amenorrhea	☐ Yes ☐ No	h. Uterine Fibroma	☐ Yes ☐ No

Date of last menstrual cycle: ____/____/____/

Are you on oral birth control pills? ☐ Yes ☐ No

i. Are you pregnant? ☐ Yes ☐ No j. Are you breastfeeding? ☐ Yes ☐No

9 Endocrine Function:

a .Do you have thyroid problems? ☐ Yes ☐ No If so, please specify: _____

b. Do you have parathyroid problems? ☐ Yes ☐ No If so, please specify: _____

c. Do you have adrenal gland problems? ☐ Yes ☐ No If so, please specify: _____

Have you been told you have Metabolic Syndrome (also called "Syndrome X")? ☐ Yes ☐ No

10. Neurological/Emotional Function:

Do any of the following apply to you?

a. Bipolar Disorder	☐ Yes ☐ No	f. Panic Attacks	☐ Yes ☐ No
b. Parkinson's disease	☐ Yes ☐ No	g. Anorexia (History of)	☐ Yes ☐ No
c. Epilepsy (NPA)	☐ Yes ☐ No	h. Bulimia (History of)	☐ Yes ☐ No
d. Alzheimer's disease	☐ Yes ☐ No	i. Schizophrenia	☐ Yes ☐ No
e. Depression	☐ Yes ☐ No	j. Anxiety	☐ Yes ☐ No

Other issues: _____

11. Inflammatory Conditions:

Do any of the following apply to you?

a.☐ Migraines d. ☐ Fibromyalgia f. ☐ Rheumatoid g. ☐ Lupus

b.☐ Psoriasis e. ☐ Chronic Fatigue Syndrome h. ☐ Multiple Sclerosis i. ☐ Osteoarthritis

c.☐ Other autoimmune or inflammatory condition

12. Cancer:

a. Do you have Cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

b. Have you ever had Cancer? (NPC) ☐ Yes ☐ No

If so, what type and where is it located? _____

When was the Cancer diagnosed? ____/____/____/

c. Is your Cancer in remission? (NPC) ☐ Yes ☐ No

If so, how long have you been in remission? _____ (mo/yrs)

13. General:

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

If so, please specify:

_____ _____

_____ _____

14. Allergies:

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

If so, please list:

_____ _____

_____ _____

15. 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 have a **snack** at night? ☐ Yes ☐ Sometimes ☐ Never
Approximate time: _____

Examples:

_____
_____
_____

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, packs per day _____ for how many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often?

_____

Contact Information

Point Finger Road Medical Center
16 Point Finger Road
Paget DV 04
Tele: 236-0410
Fax: 236-4469
Email: pfrwellness@gmail.com
Website: www.bermudaweightloss.com

16. Medications AND BLOOD WORK

Dear Client: Please complete this form by listing all prescription medications and supplements that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet? *	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500 mg	1	1 x a day	Dr. John Doe	Omega 3

BLOOD PRESSURE: _____/_____
HBA1C:_____
FASTING BLOOD GLUCOSE:
HDL CHOLESTEROL:
LDL CHOLESTEROL:
TRIGYLCERIDES:

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 / underlined / 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 clinic 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 clinic as well as Ideal Protein of America 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[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 clinic 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 Releases that I may have or choose to make shall only be submitted to binding arbitration under the rules and guidelines of the American Arbitration Association, and I waive any rights to pursue any claims or causes of action in any court of law.

SIGNED _____ on this ____ day of _____, 2019

Witness:

_____ _____

(Signed) (Signed)

Name of client (print):_____ Name of witness:_____

Last Name: _____ First Name: _____ DOB: ____/____/____/

_____ Initials