MEDICAL CHECK LIST & MEDICAL APPROVAL

Please ☐ if you *have* or *have had* any of the following conditions or circumstances:

Clients with any of the medical conditions listed below are not currently eligible (NE) for the ShiftSetGo weight loss program.

☐ Severe Liver Disease
☐ Severe Kidney Disease
☐ Diagnosis of Parkinson's
☐ Currently on Lithium Therapy
☐ Heart Attack within 6 Months
☐ Currently Undergoing Cancer Treatment
☐ Strict Vegan Lifestyle
☐ Currently Pregnant
☐ Alzheimer's Disease
☐ **None *of These Conditions Apply***

The conditions below require a Physician Signature (PS)

Clients with any of the medical conditions listed below will be sent to their primary care doctor or specialist along with the Authorization to Use Protected Health Information (PHI) medical release form.

☐ Arrhythmia (Abnormal Heart Rhythm)
☐ Kidney Disease
☐ Kidney Transplant
☐ Coronary Artery Disease
☐ Heart Valve Problem
☐ Epilepsy -seizure w/in 1 year
☐ Blood Clot-Taking Blood Thinner
☐ Hyperkalemia (High Potassium Level)
☐ Pulmonary Embolism- Taking Blood Thinner
☐ Currently on Steglatro Invokana, Jardiance or Farviga (SGLT-2)
☐ Stroke or Transient Ischemic Attack (TIA)
☐ History of Congestive Heart Failure
☐ Child Under Age 17 (Pediatrician Approval)
☐ Gastric Ulcer
☐ Heart Valve Replacement
☐ History of Heart Attack w/in 1 year (Cardiologist Approval)
☐ Hypokalemia (Low Potassium Level)
☐ History of Cancer:
  ☐ 5 Years or Less
  ☐ More than 5 years
☐ **None *of These Conditions Apply***

Clients with any of the medical conditions listed below will be asked to closely monitor their medications and allow us to send progress updates to your physician. You may also be placed on our modified plan.

☐ Type II Diabetic ☐ Taking high blood pressure medication ☐ Taking Coumadin

Clients with the following will be on the Modified ShiftSetGo weight loss program:

☐ Currently Breast Feeding
☐ Type 1 Diabetic

Do you have a surgery within the next month? Yes/No
Do you have a vacation scheduled within the next month? Yes/No

*Please talk to a Coach prior to your Initial Consultation if you have any questions regarding this Medical Condition Checklist or the accompanying Medical Release form.

_____

CLIENT SIGNATURE PRINTED NAME **DATE**

****

I have reviewed the ShiftSetGo Weight Loss Method Overview and approve_____ to participate in the ShiftSetGo Weight Loss program.

PHYSICIAN/PROVIDER SIGNATURE PRINTED NAME DATE

Required: PS= Physician Signature required prior to starting the program NE=Not Eligible for program

Health Summary Overview

Dietary consultation involves a health summary overview. We are not a medical facility and our staff cannot and will not provide any medical or psychological advice. 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.

1. Overall (please use print characters)

First name: _____ Last name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Best Phone: _____ Email: _____

Date of birth: _____(under 18 **PS**) Height: _____ Do you know your current weight?: _____

Profession: _____ Referral: _____

Do you exercise? ___ Yes ___ No If yes, what kind? _____ How often? ___Daily ___Weekly ___ Other

If you have tried to lose weight before 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 the level of importance you give to losing weight: (circle one)

Not important **1 2 3 4 5 6 7 8 9 10** Very important

Who does the cooking in your home? _____ If not you, is the cook supportive of your weight loss journey? _____

Who is your primary care physician (family doctor)? _____

Please list any physicians you see and their specialty (refer to medical information for lists of disorders):
Dr. _____ Specialty: _____ Patient since: _____(mm/yy)

Dr. _____ Specialty: _____ Patient since: _____(mm/yy)

2. Diabetes ___N/A If no, please skip to next section.

Do you have diabetes? ___Yes ___No

Which Type? ___ Type I - Insulin-Dependent (insulin injections only) **NE *Must do our Modified Program**
___ Type II - Non-insulin-dependent (diabetic pills only)
___ Type II - Insulin-dependent (diabetes pills & insulin) ***Please watch your insulin intake & check BS carefully**

Is your blood sugar level monitored? ___Yes ___No If so, how often? _____ By whom? ____Myself ___Physician

Do you tend to be hypoglycemic? ___Yes ___No

Note: If you are currently on Steglatro, Invokana, Jardiance, Farxiga **(SGLT-2), do not start the weight loss method.** PS

3. Kidney Function ___N/A Have you had any of the following conditions:

___Kidney Disease (severe **PS**) ___Kidney Transplant **PS** ___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:

_____

4. Cardiovascular Function ___N/A

Have you had any of the following conditions:

___Arrhythmia **PS**
___Hyperkalemia (High potassium) **PS**
___Blood Clot **PS w/in 6 months**
___Hypokalemia (Low potassium) **PS**
___History of Congestive Heart Failure **PS**
___Coronary Artery Disease **PS**
___Current Congestive Heart Failure **NE**
___Heart Attack **PS/NE w/in 6 months**
___Hyperlipidemia (High cholesterol/triglycerides)
___Pulmonary Embolism **PS w/in 6 months**
___Taking coumadin *watch veggies
___Pace Maker *No body comp
___Heart Valve Problem/Replacement **PS**
___Stroke or Transient Ischemic Attack **PS**
___Congestive Heart Failure **PS**
___**Hypertension (High blood pressure)** **Taking medication? Yes/No**

Have you ever had any type of cardiac/heart surgery? ___Yes ___No If yes, which type? _____

Other conditions:_____

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

5. Liver Function ___N/A

Have you ever had any liver conditions? ___Yes ___No Date: _____ Severe Liver Disease PS

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, are you currently experiencing a flair up: _____

7. Digestive Function ___N/A

Do you have any of the following conditions:

___Acid Reflux ___Gluten intolerance ___Celiac Disease ___Heartburn ___Gastric Ulcer

___History of Bariatric Surgery **PS w/in 12 months** If so, what type of Bariatric Surgery? _____Date:_____

8. Ovarian/Breast Function ___N/A

Do you currently have any of the following conditions:

___Amenorrhea ___Irregular Periods ___Fibrocystic Breasts ___Menopause

___Heavy Periods ___Painful periods ___Hysterectomy ___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
**If yes must do Shift Mamas Program*

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: _____

10. Neurological/Emotional Function ___N/A

Do you have any of the following conditions:

___Alzheimer's disease **NE** ___Depression ___Anxiety ___Epilepsy ___Bipolar Disorder

___Parkinson's disease **NE** ___Schizophrenia ___Anorexia (History of) ___Bulimia (History of)

Are you on Lithium Therapy? **NE** ___Yes ___No Other issues: _____

11. Inflammatory Conditions ___N/A

Do you have any of the following conditions:

___Multiple Sclerosis ___Fibromyalgia ___Osteoarthritis ___Lupus

___Psoriasis ___Migraines ___Rheumatoid ___Chronic Fatigue Syndrome

___Other autoimmune or inflammatory condition: _____

12. Cancer ___N/A

Do you have cancer? **PS** ___Yes ___No If so, what type and where is it located? _____

Have you ever had cancer? ___Yes ___No If so, what type and where is it located? _____

Is your cancer in remission*? ___Yes ___No If so, how long have you been in remission? _____(mm/yy)

*** PS if not in remission for 5 years or more**

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: _____

15. Medications & Supplements.

Please list all prescriptions medications and supplements you are currently taking.

Name of medication	Milligrams* per capsule	Number of capsules per day	Number of doses per day	Prescribing doctor	Reason for taking this medication

*Or grams, mEq or dosage unit your doctor prescribes.

Medical Disclaimer and Waiver

I, _____, understand, acknowledge, and affirm the following:

LOW CARB CLINIC, and its subsidiaries are not a medical facility, and it, its consultants and staff cannot, have not, and will not give medical advice, diagnosis or treatment, whatsoever. Nothing discussed, nor any information or products provided to me at LOW CARB CLINIC. in any way constitutes medical advice or diagnosis.

Any reports, information, documentation, or advice generated or provided to me by LOW CARB CLINIC. is for my education or knowledge and does not constitue or substitute for physician or health care professional consultation, evaluation, or treatment.

I, _____ (initials), acknowledge that it is my responsibility to consult with my physician prior to beginning the LOW CARB CLINIC. program or any weight loss program. I declare that I have been advised by LOW CARB CLINIC. to seek the advice of my physician regarding any health questions I may have.

I, _____ (initials), recognize that LOW CARB CLINIC. is a weight loss program and any information provided by LOW CARB CLINIC. is for my knowledge only and does not substitute for professional medical advice.

I, _____ (initials), declare that I have not, and will not rely on any information provided to me by LOW CARB CLINIC, its consultants, staff or representatives as an alternative to medical advice from my doctor or professional health care provider.

I confirm that the information that I have provided to my coach and that is recorded by me on this Health Summary 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 listed on page 1 and that I am not taking any medications not specifically stated on this form. Furthermore, I understand that I should not be undertaking or otherwise following the program if I have any of the said conditions in part 1 of page 1 unless i) I specifically consult with a medical doctor concerning my suitability to go on the program, ii) remain under the supervision of said medical doctor while I am on the program, and iii) provide documentation confirming the foregoing.

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 Program.

By signing this Disclaimer and Waiver I, _____ (print name), do hereby release, remise, acquit and forever discharge LOW CARB CLINIC, all of LOW CARB CLINIC, respective past, present and former parents, subsidiaries, employees, agents, representatives, consultants, attorneys, fiduciaries, servants, officers, directors, general partners, limited partners, members, participants, predecessors, affiliates, corporate divisions, successors, and assigns of, from, and against any and all causes of action, claims demands, damages, costs, losses, injuries, and suits of any kind or nature, known or unknown, existing, claimed to exist or which can be hereinafter ever arise out of result from or in connection with any act, omission, failure to act, breech of conduct suffered to be done or omitted to be done arising directly or indirectly from my participation in the LOW CARB CLINIC. weight loss program.

CLIENT SIGNATURE: _____ DATE: _____

CLIENT AGREEMENT

THIS AGREEMENT is made as of the date indicated below between ShiftSetGo LLC (SSG) and the undersigned ("Client") (collectively as the "Parties"). The Parties agree to the following:

1. **Confidentiality.** The Parties agree that neither party shall authorize the other to disclose to any third party any confidential information without prior written consent, except as may be necessary to establish or assert rights hereunder, as required by the laws of the applicable jurisdiction or by court order. Confidential Information includes any personal health information disclosed by Client. Confidential information is not limited to a specific medium and can be oral, written or physical in format. The confidentiality obligations set forth in this Agreement shall survive 10 years after termination or expiration of the Agreement.

2. **Intellectual Property - SSG Materials**. All original materials provided by SSG to Client are owned by SSG. Any original materials are provided for Client's individual use only. Client is not authorized to use or transfer any of SSG's intellectual property. All intellectual property remains the property of SSG. No license to sell or distribute is granted or implied.

3. **Limitation of Liability.** CLIENT AGREES THAT IT HAS USED SSG'S SERVICES AT ITS OWN RISK. CLIENT RELEASES SSG FROM ANY AND ALL CLAIMS OF DAMAGES THAT MAY RESULT FROM ANY CLAIMS ARISING FROM THIS AGREEMENT, ALL ACTIONS, CAUSES OF ACTION, CONTRACT CLAIMS, SUITS, COSTS, DEMANDS, AND DAMAGES OF WHATEVER NATURE OR KIND IN LAW OR IN EQUITY ARISING FROM THIS AGREEMENT.

4. **No Warranty**. All information is provided "as is" with no warranties.

5. **Choice of Law and Jurisdiction.** This Agreement shall be governed by the laws of the State of Washington without regard to its conflict of laws doctrine, and applicable federal laws of the United States of America.

6. **Assignment.** This Agreement shall not be transferred or assigned to any third party, in whole or in part, by Client without the express written consent of SSG, which may be withheld in SSG's sole discretion.

7. **Miscellaneous.**

   a) If any of the provisions of this Agreement is or becomes illegal, unenforceable, or invalid (in whole or in part for any reason), the remainder of this Agreement shall remain in full force and effect without being impaired or invalidated in any way.

   b) Any rights or obligations contained herein that by their nature should survive termination of the Agreement shall survive, including, but not limited to representations, warranties, intellectual property rights, indemnity obligations, and confidentiality obligations.

   c) Any failure of either party to enforce any provision of this Agreement, or any right or remedy provided for therein, shall not be construed as a waiver, estoppel with respect to, or limitation of that party's right to subsequently enforce and compel strict compliance or assertion of a remedy.

   d) This Agreement, along with all attachments, represents a single agreement, as well as the entire agreement with respect to the subject matter. This Agreement supersedes any prior agreement between the parties, whether written or oral, with respect to the subject matter, and may be modified or amended only by a writing signed by the party to be charged.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement as of the day and year written below.

CLIENT SIGNATURE: _____ DATE: _____