## Health Profile

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| 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 | | | | | | | | | | | | | | | | | | | |
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| **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.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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? | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | |
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| **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: | | | |  | | | | | | | | | |  | |
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| **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. | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **3. Cardiovascular Function**  N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had any of the following conditions? | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Arrhythmia (NPA) | | | | | | | | | |  | | Hyperkalemia (High potassium) (NPA) | | | | | | | | | | | | |
|  | | Blood Clot (NPA) | | | | | | | | | |  | | Hypokalemia (Low potassium) (NPA) | | | | | | | | | | | | |
|  | | Coronary Artery Disease (NPA) | | | | | | | | | |  | | Hypertension (High blood pressure) (NPA) | | | | | | | | | | | | |
|  | | Heart attack (NPC) | | | | | | | | | |  | | Pulmonary Embolism (NPA) | | | | | | | | | | | | |
|  | | Heart Valve Problem (NPA) | | | | | | | | | |  | | Stroke or Transient Ischemic Attack (NPA) | | | | | | | | | | | | |
|  | | Heart Valve Replacement (porcine/ mechanical) (NPA) | | | | | | | | | |  | | Congestive Heart Failure (NPC) | | | | | | | | | | | | |
|  | | Hyperlipidemia | | | | | | | | | |  | | Please select one (if applicable): | | | | | | | | | | | | |
|  | | (High cholesterol/triglycerides) | | | | | | | | | |  | | History of Congestive Heart Failure | | | | | | | | | | | | |
|  | |  | | | | | | | | | |  | | 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: | | | | | | | | | | | | | |
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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: | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | |  | | | | | | |
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| **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: | | | | | | | | | | | | | | | | | | | | | | |
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| **7. Digestive Function**  N/A | | | | | |
| Do you have any of the following conditions: | | | | | |
|  | Acid Reflux | |  | Gluten intolerance | |
|  | Celiac Disease | |  | Heartburn | |
|  | Gastric Ulcer (NPA) | |  | 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: | | | | | | | | | | | | | | | | | | |
|  | 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 | |  | |  | |  | |  |
|  | | | | | | | | | | | | | | | | | | |
| **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 | |  | |  | |  |  |
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| **10. Neurological/Emotional Function**  N/A | | | | | |
| Do you have any of the following conditions: | | | | | |
|  | Alzheimer’s disease | |  | Depression | |
|  | Anorexia (History of) | |  | Epilepsy (NPA) | |
|  | Anxiety | |  | Panic attacks | |
|  | Bipolar disorder | |  | Parkinson’s disease | |
|  | Bulimia (History of) | |  | Schizophrenia | |
| Other issues: | |  | | |  |
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| **11. Inflammatory Conditions**  N/A | | | | | | | | | | | | | | | | | | | | | |
| Do you have any of the following conditions: | | | | | | | | | | | | | | | | | | | | | |
|  | Chronic Fatigue Syndrome | | | |  | | | Multiple Sclerosis | | | | | | | | | | | | | |
|  | Fibromyalgia | | | |  | | | Osteoarthritis | | | | | | | | | | | | | |
|  | Lupus | | | |  | | | Psoriasis | | | | | | | | | | | | | |
|  | Migraines | | | |  | | | Rheumatoid | | | | | | | | | | | | | |
|  | Other autoimmune or inflammatory condition | | | | | | | | | | | | | | | | | | | | |
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| **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) | | | |  | |  | |  |  |
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| **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: |  | | | | | | | |  |
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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: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Do you have a snack before lunch? | | | | | |  | Yes |  | Sometimes | |  | No |  | Never | |
| Approximate time: | | |  | | |  |  |  |  |  |  |  |  |  |  |
| Examples: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **LUNCH** | | | | | | | | | | | | | | | |
| Do you have lunch every day? | | | | | |  | Yes |  | Sometimes | |  | No |  | Never | |
| Approximate time: | | |  | | |  |  |  |  |  |  |  |  |  |  |
| Examples: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Do you have a snack before dinner? | | | | | |  | Yes |  | Sometimes | |  | No |  | Never | |
| Approximate time: | | |  | | |  |  |  |  |  |  |  |  |  |  |
| Examples: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **DINNER** | | | | | | | | | | | | | | | |
| Do you have dinner every day? | | | | | |  | Yes |  | Sometimes | |  | No |  | Never | |
| Approximate time: | | |  | | |  |  |  |  |  |  |  |  |  |  |
| Examples: | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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 |
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| \*Or grams, mEq or dosage unit your doctor prescribes. | | | | | |

**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 ProteinTM Protocol service provider (the ”**Clinic**”) and that is recorded by me on this Ideal ProteinTM 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 ProteinTM 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 ProteinTM Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal ProteinTM 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 ProteinTM 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 ProteinTM Protocol.

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

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

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| Signed in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (city/state), on this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_. | | | | | | | | | |
| Name of witness (print): | |  | | |  |  |  |  |  |
| Name of client (print) | |  | | |  |  |  |  |  |
|  |  | |  |  | | | | |  |
|  | Client Signature | |  | Witness Signature | | | | | |