Health Profile

Dietary consultation involves a health profile whose purpose 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.

General

Last Name: ___________________________ First Name: _____________________

Address: _______________________________________ Apt/Unit: # ____________

City: _________________________________ State: _________ Zip:____________

Phone: _____________________ Cell:________________ E-mail: ____________

Date of Birth: ________________ Age: _____ Profession: _____________________

Whom may we thank for referring you? _____________________________________

Weight: ____lbs. Weight 1 year ago: ____ lbs. Min. Adult Weight: _____lbs at age _____
Maximum Weight: _____ lbs. at age ______ Height: __________

Do you exercise? □ Yes □ No
If yes, what kind? ____
____

How often? ____
____

Have you been on a diet before? □ Yes □ No _________________________________
If yes, please specify which diet 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 medically supervised weight loss method (10 being the most important): _____

***Family Life*:**

What is your marital status? M S D W   Do you have children? □ Yes □ No
Number of children: _________ Ages: _________________________

***Medical Information*:**

Please list any physicians you see and their specialty:

____

____

____

____

***Diabetes*:**

Do you have diabetes? □ Yes □ No (if no, skip to next section)

If so, are you under the care of a physician? □ Yes □ No

If so, 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, by whom? □ Myself □ Physician □ Other (specify):

____

Are you taking any medication? □ Yes □ No
If so, please list:

____

Do you tend to be hypoglycemic? □ Yes □ No

***Cardiovascular Health*:**

Have you had a cardiovascular event? □ Yes □ No (if no, skip to next section)
If so, please specify:

____

How long ago?

____

If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

____

Do you have a history of arrhythmia □ Yes □ No

***Hypertension*:**

Do you have high blood pressure? □ Yes □ No (if no, skip to next section)
If so, do you have your blood pressure checked? □ Yes □ No
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

____

Kidney Health:

Have you been diagnosed with kidney disease? ◻ Yes ◻ No (if no, skip to next section)
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:

____

Have you ever had Gout? ◻ Yes ◻ No

Liver Health:

Do you have liver problems? ◻ Yes ◻ No (if no, skip to next section)
If so, please specify:

____

If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:

____

***Colon Health*:**

Do you have: ◻ Irritable Bowel ◻ Colitis ◻ Diarrhea ◻ Diverticulosis?
◻ Crohn's disease ◻ Constipation
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:

____

***Stomach/Digestive Health*:**

Do you have: ◻ Acid Reflux ◻ Gastric Ulcer ◻ Heartburn ◻ Celiac Disease?
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:

____

Ovarian/Breast Health:

Check off the situations that apply to you currently:
◻ Irregular Periods ◻ Menopause ◻ Fibrocystic Breasts
◻ Painful Periods ◻ Hysterectomy ◻ Heavy periods
◻ Amenorrhea ◻ Uterine fibroma ◻ Cancer (uterus, breast)
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:

____

Please indicate the date of your last menstrual cycle:

____

***Thyroid Function*:**

Do you have thyroid problems? ◻ Yes ◻ No (if no, skip to next section)
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:
____

***Emotional Evaluation*:**

Do any of the following apply to you? (if no, skip to next section)
◻ Depression ◻ Anxiety ◻ Panic Attacks
◻ Bulimia (or history of) ◻ Anorexia (or history of)
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:
____

***Inflammatory Conditions*:**

Do any of the following apply to you? (if no, skip to next section)
◻ Migraines ◻ Fibromyalgia ◻ Rheumatoid Arthritis ◻ Lupus
◻ Osteoarthritis
◻ Chronic Fatigue Syndrome ◻ Psoriasis
◻ Other autoimmune or inflammatory condition:
____

If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list:
____

***General*:**

Do you have cancer? ◻ Yes ◻ No
Are you in cancer remission? ◻ Yes ◻ No
If so, please specify and indicate for how long: ______________________________
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any medication? ◻ Yes ◻ No
If so, please list: ____

Are you generally fatigued or have low energy? ◻ Yes ◻ No

Are you pregnant? ◻ Yes ◻ No Are you breastfeeding? ◻ Yes ◻ No

Do you get cold easily? ◻ Yes ◻ No Do you have cold hands/feet? ◻ Yes ◻ No

Do you have other health problems? ◻ Yes ◻ No
If so, please specify: ____
If so, are you under the care of a physician? ◻ Yes ◻ No
Are you taking any other medications not listed above? ◻ Yes ◻ No
If so, please list: ____

Are you currently taking Vitamins, Herbs or Supplements? □ Yes □ No

Vitamin, Herb or Supplement Name **Reason**

1. ____
2. ____
3. ____
4. ____
5. ____

***Allergies*:**

Do you have any **food** allergies? □ Yes □ No
If so, please list:
____

Do you have any **medication** allergies? □ Yes □ No
If so, please list:
____

***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 eat a **snack** at night? □ Yes □ Sometimes □ Never
Approximate Time: ______________
Examples: ____
____

Other:
Do you prefer: □ Sweet foods □ Salty foods □ Fatty foods
Are you a vegetarian? □ Yes □ No
How many glasses of water do you drink per day? __________ glasses
How many cups of coffee do you drink per day? __________ cups
Do you smoke? □ Yes □ No
If yes, how many packs per day? ______ for how many yrs? __________
Do you drink alcohol? □ Yes □ No
If yes, what, how much, and how often? ____
____

CASH Scale: Compulsions or **C**ravings/**A**ppetite/**S**atiety/**H**unger
Score each item on a 0—10 numbering scale. Each feeling represents a different part of the brain and different neurotransmitters

Compulsions/Cravings

Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Never occurs Constant

Appetite

Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Never eat more Always eat more

Satiety

A feeling of fullness acquired during eating. When you eat, you usually:

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Leave food on plate one plate only second's thirds

Hunger

That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort.

0---1-----2—--3—--4—--5—--6—--7—--8—--9—--10
Never hungry Constant hunger

You must take vitamins and minerals while you are on the Ideal Protein Weight-Loss Method. If you stop taking them, you may experience undesirable side effects. _____ (Client's initials)

If you are taking medications, are you interested in getting off of any or all of your prescription medications? ▫ Yes ▫ No

If you have health problems not indicated on this health profile, please consult your physician.

Signature: _________________________ Date: _____________________

The signatory client hereby recognizes the veracity of the information provided herein and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.

*Disclaimer:

A history of **Congestive Heart Failure (CHF), Atrial Fibrillation, Parkinson's disease** or **Lithium prescription** are **ABSOLUTE CONTRAINDICATIONS** to the Ideal Protein Weight Loss Method, regular or alternative. No non-medical Ideal Protein Clinic may ever accept such a person as a dieter. The only exceptions are **licensed medical doctors** (MD or DO). These practitioners may accept such patients, if in their professional judgment our protocol would be a benefit to their health. By accepting such a dieter, the physician will assume all responsibility for this patient's health as per their medical license.