

## **Health Profile**

Legend (For clinic use)

The Protocol

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.

NPA - Needs Preso	criber Approva	Approval NPC - Needs Prescriber Care						are	
4 Overell (D)									
1. Overall (Please	e use print char	acters)							
First name:					Last r	name:			
Address:								Apt	:./unit:
City:					;	State:		Zip	code:
Phone:					M	lobile:			
Email:									
Date of birth:						Age:			<del>-</del>
Profession:									
Referral:									
Current weight (lb):			W	√eigh	t 1 yea	ır ago (lb	):		
Minimum adult weig	ght (lb):			At	age:			_	
Maximum adult we	ight (lb):								
Do you exercise?			Yes			If yes, v			
How often?			Daily		Weekl	y		Other	
Have you been on If yes, please speci involved, etc.)			hy you th	☐ nink it	Yes didn't		No you (	(i.e. too	rigid, too much cooking
On a scale of 1 to 1 professionally supe				tance	you g	ive to los	sing w	eight w	rith Ideal Protein's
Least important	1 2	3 4	5	6	7	8	9	10	Very important
What is your marita	al status?		Married Divorce			Single Other:			Widow
How many children	do you have	?			How	old are th	ey?		
Who does most of				1.10					
On average, how m	nany hours do	you sle	ep per ni	gnt?					
Last name:		First nam	۵.			DOF	₹.		(DD/MM/YY) Initials:

Revised January 16, 2017 (US)



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.	1. Overall (continued)		
Dr.   Specialty:   Patient since:   (MM/YY)   Last visit:	Who is your primary care	physician (family docto	or)?
Patient since:	Please list any physicians	you see and their spec	cialty (refer to medical information for list of disorders):
Dr.   Specialty:   Patient since:   (MMYY)   Last visit:    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.  3. Cardiovascular Function   N/A   Have you had any of the following conditions?   Hyperkalemia (High potassium) (NPA)     Blood Clot (NPA)   Hypokalemia (Low potassium) (NPA)     Hypokalemia (Low potassium) (NPA)   Hypokalemia (Low potassium) (NPA)     Heart Valve Problem (NPA)   Pulmonary Embolism (NPA)     Heart Valve Problem (NPA)   Stroke or Transient Ischemic Attack (NPA)	Dr.		Specialty:
Patient since:	Patient since:	(MM/YY)	Last visit:
Dr.   Specialty:   Patient since:	Dr.		Specialty:
Patient since:	Patient since:	(MM/YY)	Last visit:
Dr.   Specialty:   Patient since:	Dr.		Specialty:
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Do you have diabetes?			
Do you have diabetes?	2 Diabetes	٨	
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.  3. Cardiovascular Function N/A  Have you had any of the following conditions? Hyperkalemia (High potassium) (NPA) Hood Clot (NPA) Hypokalemia (Low potassium) (NPA) Hypokalemia (Low potassium) (NPA) Hyportension (High blood pressure) (NPA) Heart attack (NPC) Heart Valve Problem (NPA) Heart Valve Problem (NPA) Heart Valve Replacement (porcine/	_		s No If no please skip to peyt section
Type II – Non-insulin-dependent (diabetic pills) Type II – Insulin-dependent (diabetic pills and insulin) Is your blood sugar level monitored? If so, by whom?    Myself		_	
Is your blood sugar level monitored?			
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.  3. Cardiovascular Function   N/A     Have you had any of the following conditions?   Hyperkalemia (High potassium) (NPA)     Blood Clot (NPA)   Hypokalemia (Low potassium) (NPA)     Heart attack (NPC)   Pulmonary Embolism (NPA)     Heart valve Problem (NPA)   Stroke or Transient Ischemic Attack (NPA)     Heart Valve Replacement (porcine/		☐ Typ	pe II – Insulin-dependent (diabetic pills and insulin)
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.  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)	Is your blood sugar level m	onitored?	s 🗌 No If so, how often?
Do you tend to be hypoglycemic?	If so, by whom?		
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Have you had any of the following conditions?  Arrhythmia (NPA) Blood Clot (NPA) Coronary Artery Disease (NPA) Heart attack (NPC) Heart Valve Problem (NPA) Heart Valve Replacement (porcine/  Hyperkalemia (High potassium) (NPA) Hypokalemia (Low potassium) (NPA) Hypertension (High blood pressure) (NPA) Pulmonary Embolism (NPA) Stroke or Transient Ischemic Attack (NPA)	Protocol.		
Have you had any of the following conditions?  Arrhythmia (NPA) Blood Clot (NPA) Coronary Artery Disease (NPA) Heart attack (NPC) Heart Valve Problem (NPA) Heart Valve Replacement (porcine/  Hyperkalemia (High potassium) (NPA) Hypokalemia (Low potassium) (NPA) Hypertension (High blood pressure) (NPA) Pulmonary Embolism (NPA) Stroke or Transient Ischemic Attack (NPA)	3 Cardiovaccular E	Inction D N/A	
Arrhythmia (NPA)  Blood Clot (NPA)  Coronary Artery Disease (NPA)  Heart attack (NPC)  Heart Valve Problem (NPA)  Hyperkalemia (High potassium) (NPA)  Hypokalemia (Low potassium) (NPA)  Hypertension (High blood pressure) (NPA)  Pulmonary Embolism (NPA)  Stroke or Transient Ischemic Attack (NPA)  Heart Valve Replacement (porcine/			
□ 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/	<u> </u>	ollowing conditions:	Upporkalamia (High natassium) (NDA)
<ul> <li>□ Coronary Artery Disease (NPA)</li> <li>□ Hypertension (High blood pressure) (NPA)</li> <li>□ Pulmonary Embolism (NPA)</li> <li>□ Heart Valve Problem (NPA)</li> <li>□ Stroke or Transient Ischemic Attack (NPA)</li> <li>□ Heart Valve Replacement (porcine/</li> </ul>			
<ul> <li>☐ Heart attack (NPC)</li> <li>☐ Heart Valve Problem (NPA)</li> <li>☐ Heart Valve Replacement (porcine/</li> </ul> Pulmonary Embolism (NPA) Stroke or Transient Ischemic Attack (NPA)		sease (NPA)	
Heart Valve Replacement (porcine/		,	
			Stroke or Transient Ischemic Attack (NPA)
mechanican (NPC)		ement (porcine/	Congostina Heart Failure (NDC)
Hyperlipidemia Please select one (if applicable):			
(High cholesterol/triglycerides)  History of Congestive Heart Failure		alvcerides)	
Current Congestive Heart Failure (NPC)	\g 3.1313333131411	g., - cc.,	



<b>l. Cardiovascular Function</b> (cont.) lave you ever had <b>any</b> type of heart surgery	N/A ?[	Yes	3	No		
so, which type?						
Other conditions:	00 to ditio			ما الم	.t of	
you have answered yes to any of the above	conditio	ns, pież	ise give	an da	ites of occurrence:	
. Kidney Function   N/A						
ave you had any of the following conditions:						
Kidney Disease (NPA)						
☐ Kidney Transplant (NPA)						
Kidney Stones	_					
☐ Do you presently have gout? ☐	Yes		No		Since when:	
yes, what medication has been prescribed?						
, ,						
		Yes		No		
no, have you ever had gout? yes, when?	es of eve	_	multipl		nts please specify:	
no, have you ever had gout?  yes, when?  yes to any of these events, please give date	es of eve	_	multipl		nts please specify:	
ino, have you ever had gout? iyes, when? iyes to any of these events, please give date  Liver Function N/A	es of eve	_	multipl		nts please specify:	
ino, have you ever had gout? iyes, when? iyes to any of these events, please give date  Liver Function  N/A  lave you ever had any liver conditions?	es of eve	nts. For	multipl	e ever		
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  ave you ever had any liver conditions?  yes, please list:	es of eve	nts. For	multipl	e ever		
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  ave you ever had any liver conditions?  yes, please list:	es of eve	_ nts. For Yes	multipl	le ever		
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  ave you ever had any liver conditions?  yes, please list:  ave you ever had a gallstone incident?	es of eve	_ nts. For Yes	multipl	le ever		
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  ave you ever had any liver conditions?  yes, please list:  ave you ever had a gallstone incident?  Colon Function	es of eve	_ nts. For Yes	multipl	le ever		
ino, have you ever had gout?  if yes, when?  if yes to any of these events, please give date  if yes to any of these events, please give date  if yes, please give date  if yes, please list:  if yes,	es of eve	_ nts. For Yes	Diverti	No No iculitis	Date:	
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  lave you ever had any liver conditions?  yes, please list: lave you ever had a gallstone incident?  Colon Function  N/A  o you have any of the following conditions:  Constipation  Crohn's Disease	es of eve	_ nts. For Yes	Diverti	No No iculitis le Bow	Date:	
no, have you ever had gout?  yes, when?  yes to any of these events, please give date  Liver Function  N/A  lave you ever had any liver conditions?  yes, please list: lave you ever had a gallstone incident?  Colon Function  N/A  o you have any of the following conditions:  Constipation  Crohn's Disease  Diarrhea		Yes Yes	Diverti Irritabl Ulcera	No No iculitis le Bow	Date:el Syndrome olitis	
ino, have you ever had gout?  iyes, when?  iyes to any of these events, please give date  iyes to any of these events, please give date  iyes, please give date  iyes, please list:  iyes, please give date  iyes, please give		Yes Yes	Diverti Irritabl Ulcera	No No iculitis le Bow	Date:el Syndrome olitis	y:
ino, have you ever had gout?  iyes, when?  iyes to any of these events, please give date  ixes to any of these events, please give date  ixes you ever had any liver conditions?  iyes, please list:  lave you ever had a gallstone incident?  ixes Colon Function  ixes N/A  ixes you have any of the following conditions:  ixes Colon Constipation  ixes Constituted Con		Yes Yes	Diverti Irritabl Ulcera	No No iculitis le Bow	Date:el Syndrome olitis	y:
ino, have you ever had gout?  iyes, when?  iyes to any of these events, please give date  iyes to any of these events, please give date  iyes, please list:  iyes, please give date  i		Yes Yes	Diverti Irritabl Ulcera	No No iculitis le Bow	Date:el Syndrome olitis	y:

First name: \_

Last name: \_

DOB: \_\_

\_ (DD/MM/YY) Initials: \_\_\_



7. Digestive Function   N/A	
Do you have any of the following conditions:  Acid Reflux Celiac Disease Gastric Ulcer (NPA)  If so, what type of bariatric surgery?	☐ Gluten intolerance ☐ Heartburn ☐ History of Bariatric Surgery (NPA)
8. Ovarian/Breast Function	
Do you currently have any of the following conditions:  Amenorrhea Fibrocystic Breasts Heavy periods Hysterectomy Date of last menstrual cycle: Are you taking oral contraceptive pills? Are you pregnant? Are you breastfeeding?	☐ Irregular periods ☐ Menopause ☐ Painful periods ☐ Uterine Fibroma ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9. Endocrine Function   N/A	
Do you have thyroid problems?  If so, please specify:  Do you have parathyroid problems?	☐ Yes ☐ No
If so, please specify:  Do you have adrenal gland problems?  If so, please specify:	☐ Yes ☐ No
Have you been told you have Metabolic Syndrome?	☐ Yes ☐ No

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10. Neurological/Emotional Function	□ N/A	4	
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:			
AA Leftermeter Oor Prince -			
11. Inflammatory Conditions   N/A			
Do you have any of the following conditions:		7 M Kinto Octobroito	
Chronic Fatigue Syndrome		Multiple Sclerosis	
Fibromyalgia		Osteoarthritis Psoriasis	
☐ Lupus ☐ Migraines		Rheumatoid	
<ul><li>Other autoimmune or inflammatory condition</li></ul>			
Cirici addinimane of inflaminatory condition			
40 Company			
12. Cancer N/A		7	
Do you have cancer? (NPC)	∍s ∐	No	
If so, what type and where is it located?		7 No.	
Have you ever had cancer? (NPC)	<b>3</b> S ∐	_ No	
If so, what type and where is it located?			
la vave concer in remission (NDC)		7 No.	
Is your cancer in remission? (NPC)  Ye	es 🗌	No (mm/ss)	
Is your cancer in remission? (NPC) Yes	es 🗌	No (mm/yy)	
` , —	es 🗌		
` , —	es 🗌		
If so, how long have you been in remission?	es [		
If so, how long have you been in remission?  13. General N/A	es	(mm/yy)	
If so, how long have you been in remission?  13. General N/A  Do you have any other health problems?	es	(mm/yy)	
If so, how long have you been in remission?  13. General N/A  Do you have any other health problems?	es	(mm/yy)	

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<b>14. Allergies</b>								
Do you have any food allergies or sensit	ivities?			Yes	No			
If so, please specify:								
15. Eating Habits (Please provide h	onest a	nswers	s so tha	t we can help	vou)			
BREAKFAST	J., J. J.		, 00 m		<i>y</i>			
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		Vaa		Sometimes		Nia		Navas
Do you have lunch every day?  Approximate time:	Ш	Yes	Ш	Sometimes		No	Ш	Never
Approximate time: Examples:	_							
Examples.								
Do you have a snack before dinner?		Yes		Sometimes		No		Never
Approximate time:		. 00		23110111100		. 10		110101
Examples:	_							

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			1					
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:								
OTHER								
Are you a vegan?		Yes		No				
Strict vegans do not qualify due to	o too ma	any die	tary res	striction	S.			
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 yo	ou drink	per da	y?		glasse	es per day		
How many cups of coffee do you	drink pe	er day?	•		cups	oer day		



## 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

<sup>\*</sup>Or grams, mEq or dosage unit your doctor prescribes.

Last name:	_ First name:	DOB:	(DD/MM/YY) Initials:
The Protocol		8	Revised January 16, 2017 (US)



## 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 Protein Protocol service provider (the "Clinic") 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<sup>TM</sup> 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 Protein<sup>TM</sup> Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein<sup>TM</sup> 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 Protein<sup>TM</sup> 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 Protein<sup>TM</sup> Protocol.

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

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

Signed in		_ (city/state), on this	day of	, 20
Name of witness (print):				
Name of client (print)				
Client Signature		W	tness Signatu	ire
name:	First name:	DC	)B:	(DD/MM/YY) Initials:
Protocol				Revised January 16, 2017 (US)