



## **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 professionally supervised weight loss method (10 being the most important):** \_

**Family Life:**

What is your marital status? M S D W Other Do you have children?  Yes  No  
Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

**Medical Information:**

Please list any physicians you see and their specialty:

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**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):

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Are you taking any medication?  Yes  No

If so, please list:

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Do you tend to be hypoglycemic?  Yes  No

**Cardiovascular Function:**

Have you had a cardiovascular event?  Yes  No (if no, skip to next section)

If so, please specify:

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How long ago?

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

Are you taking any medication?  Yes  No

If so, please list:

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Do you have a history of arrhythmia  Yes  No

Have you been diagnosed with Congestive Heart Failure (CHF)  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:

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**Kidney Function:**

Have you been diagnosed with kidney disease?  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:

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Have you ever had Kidney Stones?  Yes  No  
Have you ever had Gout?  Yes  No

**Liver Function:**

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

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

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**Colon Function:**

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:

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**Stomach/Digestive Function:**

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:

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**Ovarian/Breast Function:**

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:

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Please indicate the date of your last menstrual cycle:

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**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 Parkinson’s disease?  Yes  No  
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: \_\_\_\_\_



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 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.

08/17/11