402-991-BFIT(2348)

info@losingitweightloss.com

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

☐Currently UndergoingCancerTreatment
☐Severe Liver Disease
☐Severe Kidney Disease
☐Diagnosis of Parkinson 's
☐Currently on Lithium Therapy
☐Alzheimer's Disease
☐History of Congestive Heart Failure
☐Heart Attack within 6 Months
☐Strict Vegan Lifestyle
☐Currently Pregnant
☐Currently Breastfeeding
☐*None of These Conditions Apply*

- Have you been diagnosed with sleep apnea? Yes ____ No ___
  - If yes, are you being treated all night, every night? _____
- Has anyone ever told you that you snore? Yes _____ No___

Dieters with any of the medical conditions listed below will be sent to their primary care doctor or specialist along with the Ideal Protein Weight Loss Method Overview and the Authorization to Use Protected Health Information medical release form. Once signed, we ask that you follow up with our clinic prior to beginning the Ideal Protein Weight Loss Program.

☐Arrhythmia (Abnormal Heart Rhythm)
☐Blood Clot
☐Coronary Artery Disease
☐Heart Valve Problem
☐Heart Valve Replacement
☐History of Heart Attack (Cardiologist Approval)
☐Pulmonary Embolism
☐Stroke or Transient lschemic Attack (TIA)
☐Child Under Age 17 (Pediatrician Approval)
☐Kidney Disease
☐Kidney Transplant
☐Gastric Ulcer
☐Hi story of Bariatric Surgery ,(
☐Epilepsy
☐Hyperkalemia (High Potassium Level)
☐Hypokalemia (Low Potassium Level)
☐History of Cancer :
  ☐5 Years or Less
  ☐More than 5 Years
☐ *None of These Conditions Apply*

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

_____

DIETER SIGNATURE PRINTED NAME DATE

To Whom It May Concern :

I have reviewed the Ideal Protein Weight Loss Method Overview and approve the dieter above to participate in the Ideal Protein Weight Loss Program.

_____

PHYSICIAN / PROVIDER SIGNATURE PRINTED NAME DATE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient making authorization:

Full Name:

Birth Date (MM/DD/YYYY): Phone:

Address:

Healthcare provider or entity authorized to disclose this information:

Clinic/Provider Name:

Phone: Fax:

Address:

Healthcare provider or entity authorized to use this information:

Clinic/Provider Name:

Phone: Fax:

Address:

Specific information to be disclosed (check one):

☐ Medical record from:
(Enter as MM/DD/YYYY) To:

☐ Entire medical record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.

Reason for release of information: Participation in a supervised weight loss and wellness program.

The individual signing this form agrees to and acknowledges the following:

1. **Voluntary authorization:** This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing this authorization form.
2. **Effective time period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom the authorization is made or until the following specified date:
3. **Right to revoke** I understand that I have the right to revoke this authorization at any time by writing to the healthcare provider or entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. **Signature authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosure pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signatures:

Patient/Legal Representative:

Date:

If Legal Representative, relationship to Patient:

Note: A minor individual's signature may be required for the release of certain types of information, including, for example, the release of information related to certain conditions or circumstances. Please refer to the current laws in this regard and, if determined to be a requirement, have minor sign below.

Signature of minor (if applicable): Date:

Health Profile

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.

Legend (For clinic use)

NPA - Needs Prescriber Approval	**NPC -** Needs Prescriber Care

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.)

_____

_____

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? _____

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: _____

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?

- ☐ Arrhythmia (NPA)
- ☐ Blood Clot (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Heart attack (NPC)
- ☐ Heart Valve Problem (NPA)
- ☐ Heart Valve Replacement (porcine/mechanical) (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Hyperkalemia (High potassium) (NPA)
- ☐ Hypokalemia (Low potassium) (NPA)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Stroke or Transient Ischemic Attack (NPA)
- ☐ Congestive Heart Failure (NPC)

Please select one (if applicable):
- ☐ History of Congestive Heart Failure
- ☐ Current Congestive Heart Failure (NPC)

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:

_____

_____

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:

_____

_____

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

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:

_____

_____

7. Digestive Function ☐ N/A

Do you have any of the following conditions:

- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Gastric Ulcer (NPA)
- ☐ Gluten intolerance
- ☐ Heartburn
- ☐ History of Bariatric Surgery (NPA)

If so, what type of bariatric surgery? _____

8. Ovarian/Breast Function ☐ N/A

Do you currently have any of the following conditions:

- ☐ Amenorrhea
- ☐ Fibrocystic Breasts
- ☐ Heavy periods
- ☐ Hysterectomy
- ☐ Irregular periods
- ☐ Menopause
- ☐ Painful periods
- ☐ 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

10. Neurological/Emotional Function ☐ N/A

Do you have any of the following conditions:

- ☐ Alzheimer's disease
- ☐ Anorexia (History of)
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Bulimia (History of)
- ☐ Depression
- ☐ Epilepsy (NPA)
- ☐ Panic attacks
- ☐ Parkinson's disease
- ☐ Schizophrenia

Other issues: _____

11. Inflammatory Conditions ☐ N/A

Do you have any of the following conditions:

- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Migraines
- ☐ Other autoimmune or inflammatory condition
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Psoriasis
- ☐ Rheumatoid

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)

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. 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:

_____

_____

Do you have a snack before lunch? ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples:

_____

_____

LUNCH

Do you have lunch every day? ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples:

_____

_____

Do you have a snack before dinner? ☐ Yes ☐ Sometimes ☐ No ☐ Never

Approximate time: _____

Examples:

_____

_____

_____

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 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

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials: _____

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

*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 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™ 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™ Protocol, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ 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™ 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™ Protocol.

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

Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein™ 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™ 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™ 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 Witness Signature

Last name: _____ First name: _____ DOB: _____ (DD/MM/YY) Initials: _____