The Lovell Center

Health Profile

Date: _____/_____/_____

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: (circle one)

Least important 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Very/Most Important

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.

General:

(Please Print)

Last Name: _____ First Name: _____

Address: _____ Apt/Unit: # _____

City:_____State: _____ Zip/Postal Code: _____

Phone:_____Cell:_____Email: _____@_____

Date of Birth:_____/_____/_____ Age:_____ *****Profession: _____

Who may we thank for referring you?_____

Current Weight:_____lbs. Height:_____ Weight (1) year ago:_____lbs.

Minimum adult weight:_____lbs. at age_____ Maximum adult weight:_____lbs.

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 (e.g. too rigid, too much cooking involved, etc.): _____

What is your marital status? M S D W Other Do you have children? ☐Yes ☐No

How many children do you have?_____

How old are your children? _

Who does most of the cooking in your house? _____

On average, how many hours do you sleep per night? _____

Who is your primary care physician (family doctor)? _____

Physician List:

Please list any physicians you see and their specialty (refer to medical information for list of disorders):

Dr. _____Specialty:_____ Patient since:___/____(m/yr)

Address: _____ Phone: _____

Dr. _____Specialty:_____ Patient since:___/____(m/yr)

Address: _____ Phone: _____

Dr. _____Specialty:_____ Patient since:___/___(m/yr)

Address: _____ Phone: _____

Diabetes:

Do you have diabetes? ☐Yes ☐No (If not, please skip to next section)

Which type?

☐ Type I-Insulin dependent (insulin injections only)

☐Type II- Insulin dependent (diabetic pills and insulin) ***/*** Non-insulin dependent (diabetic pills)

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

Colon:

Do you have any of the following?

Irritable Bowel Syndrome	☐ Yes ☐ No	Ulcerative Colitis	☐ Yes ☐ No
Diverticulitis	☐ Yes ☐ No	Crohn's Disease	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No

If yes to any of these events, please give dates of events. For multiple events please specify:

_____

_____

_____

_____

Cardiovascular Function:

Have you had any of the following cardiovascular conditions?

- ☐ Heart Attack (NPC)
- ☐ Arrhythmia (NPA - if on Rx medications)
- ☐ Blood Clot (NPA)
- ☐ Hypertension (High blood pressure) (NPA)
- ☐ Pulmonary Embolism (NPA)
- ☐ Hyperlipidemia (High cholesterol/triglycerides)
- ☐ Stroke or TIA (NPA)
- ☐ Hypokalemia (Low Potassium) (NPA)
- ☐ Coronary Artery Disease (NPA)
- ☐ Hyperkalemia (High Potassium) (NPA)
- ☐ Heart Valve Problem (NPA)
- ☐ Congestive Heart Failure (NPC) -
- ☐ Heart Valve Replacement – porcine / mechanical (NPA)

Please select one (if applicable):

☐ History of Congestive Heart Failure ☐ Current Congestive Heart Failure (NPC)

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 these conditions, please give dates of occurrence. For multiple conditions, please specify:

_____

_____

_____

Kidney Function

Please check if any of the following applies to you:

Kidney Stones ☐ Yes ☐ No Date: _____

Kidney Disease (NPA) ☐ Yes ☐ No Date: _____

Kidney Transplant (NPA) ☐ Yes ☐ No Date: _____

Do you have Gout? ☐ Yes ☐ No If so, since when? _____

If so, what medication has been prescribed? _____

If no, have you ever had Gout? ☐ Yes ☐ No If so, when? _____

If yes to any of these events, please give dates of events. For multiple events please specify:

_____

_____

Liver:

Have you had any liver issues? (NPA) ☐ Yes ☐ No Date: _____

If yes, please list:

_____

_____

_____

Digestive Function:

Do you have any of the following?

Acid Reflux	☐ Yes	☐ No	Gastric Ulcer (NPA)	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Celiac Disease	☐ Yes	☐ No
Are you Gluten intolerant?	☐ Yes	☐ No			

History of Bariatric Surgery (NPA) ☐ Yes ☐ No

If so, what type of bariatric surgery? _____

Endocrine Function:

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 (also called “Syndrome X”)? ☐ Yes ☐ No

Ovarian/Breast Function:

Please check the situations that apply to you currently:

Irregular Periods	☐ Yes	☐ No	Menopause	☐ Yes	☐ No
Fibrocystic Breasts	☐ Yes	☐ No	Painful Periods	☐ Yes	☐ No
Hysterectomy	☐ Yes	☐ No	Heavy Periods	☐ Yes	☐ No
Uterine Fibroma	☐ Yes	☐ No	Ammenorhea	☐ Yes	☐ No

Date of last menstrual cycle:___/_____/_____

Are you pregnant? (NPA) ☐ Yes ☐ No Are you breastfeeding? (NPA) ☐ Yes ☐ No

Neurological/ Emotional Function

Check all that apply to you?

Bipolar Disorder	☐ Yes	☐ No	Panic Attacks	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No	Anorexia (History)	☐ Yes	☐ No
Epilepsy (NPA)	☐ Yes	☐ No	Bulemia (History of)	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No	Depression	☐ Yes	☐ No

Other issues: _____

Inflammatory Conditions

Check all that apply to you?

☐ Migraines ☐ Fibromyalgia ☐ Rheumatoid ☐ Lupus

☐ Psoriasis ☐ Chronic Fatigue Syndrome ☐ Multiple Sclerosis

☐ Osteoarthritis ☐ other auto-immune or inflammatory condition

Cancer

Do you have Cancer? ☐ Yes ☐ No (NPC)

If so, what type and where is it located? _____

Have you ever had Cancer? ☐ Yes ☐ No (NPC)

If so, what type and where is it located? _____

When was the Cancer diagnosed? _____/_____ (mo/yrs)

Is your Cancer in remission? ☐ Yes ☐ No (NPC)

If so, how long have you been in remission? _____/_____ (mo/yrs)

General

Do you have any other health problems? ☐ Yes ☐ No

If so, please specify: _____

Allergies

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If so, please specify: _____

Please check any of the Substances that apply to you and fill out Medications chart below with details:

☐ Yes ☐ No LITHIUM
☐ Yes ☐ No ALCOHOL
☐ Yes ☐ No COUMADIN (Warfarin)

16. Medications

Please complete this form by listing all **prescription medications and supplements** that you are currently taking. We have provided an example on the first line below of how this form should be completed.

Name of Medication	How many mg is each tablet? *	How many tablets do you take each day?	How often do you take a dose?	Prescribed by whom?	Why do you take this medication?
Vitamin X	500mg	1	1x per/day	Dr. John Doe	Omega 3

* or grams, mEq or dosage unit your doctor prescribes.

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 have a **snack** at night? ☐ Yes ☐ Sometimes ☐ Never

Approximate time: _____

Examples: _____

Are you a vegan? ☐ Yes ☐ No

Are you a vegetarian? ☐ Yes ☐ No

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

Do you smoke? ☐ Yes ☐ No

If so, packs per day_____for how many years? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, what and how often?

Confirmation of Full Health Status Disclosure & Agreement to Arbitrate Disputes

I confirm that the information that I have provided and that is recorded by me on this Sierra Wellness 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 identified as NPC or NPA on this form.**

Furthermore, I understand that I should not be undertaking or otherwise following the Ideal Protein™ Weight Loss Method if I have any of the said conditions or if I am currently talking any of the said medications/substances unless;

i) I specifically consulted with a medical doctor concerning my suitability to go on the Ideal Protein™ Weight Loss Method,
ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Weight Loss Method,
iii) and 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 and,
ii) have not disclosed same to the clinic and
iii) nevertheless chose to go on the Ideal Protein™ Weight Loss Method without specific supervision, such decision will be completely voluntary, and I release and discharge the clinic as well as Ideal Protein of America Inc., its parent companies, subsidiaries and affiliates and 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.

I confirm that the Ideal Protein Weight Loss Method has been explained to me, that I have had the opportunity to ask questions relating to the Ideal Protein Weight Loss Method, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Ideal Protein Weight Loss Method 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 Weight Loss Method.
Without limitation to the foregoing, I confirm that I have been advised that because the Ideal Protein Weight Loss Method limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Ideal Protein Weight Loss Method.

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 on the Ideal Protein Weight Loss Method.

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 and guidelines of the American Arbitration Association, 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**____**,** _____

_____ _____

(Signed) (Signed)

Name of client: (print) _____ Name of witness: (print) _____