



Ideal Protein Weight Loss Method

- Easy 4-Phase Medically Designed Protocol
- Lose an Average of 3 to 7 Pounds Per Week
- Promotes Fat Loss while Maintaining Muscle
 - Naturally Suppresses Appetite
 - Supports Cellulite Reduction
 - Promotes Vitality & Energy



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 qualify them for the program and to guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile assessment.

Personal Information:

Last Name: _____ First Name: _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Cell: (____) _____ - _____ Sex: Male Female

E-mail: _____ Date of Birth: _____ Age: _____

Marital Status: M S D W Children? Yes No If yes, what's their ages: _____

Profession: _____ Wake Time: _____ Bed Time: _____

How did you hear about Ideal Protein Weight Loss? _____

Height: _____ ft. _____ in. Current Weight: _____ lbs Weight 1 year ago: _____ lbs

Minimum Adult Weight: _____ lbs at age _____ Maximum Adult Weight: _____ lbs at age _____

Exercise regularly? Yes No If yes, what kind & how often? _____

Have you been on a diet before? Yes No If yes, within the past 12 months? 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, didn't lose weight, wasn't practical, etc.): _____

On a scale of 1 to 10 (10 being the most committed), indicate your commitment level to losing weight via Ideal Protein's professionally supervised weight loss method: _____

Medical Information:

Please list any physicians you've seen in the past 3 years.

1. _____ Specialty: _____
2. _____ Specialty: _____
3. _____ Specialty: _____
4. _____ Specialty: _____

Have you consulted any of the above physicians for weight loss advice? Yes No

General Health:

Are you currently under the care of a physician? Yes No If yes, for what: _____

Are you taking any medications? Yes No If yes, please list: _____

Do you have Parkinson's disease? Yes No (If yes, you are prohibited from the Ideal Protein protocol.)

Do you have Cancer? Yes No If yes, what type: _____

Are you in Cancer remission? Yes No If yes, how long: _____

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

Diabetes:

Do you have Diabetes? Yes No

If yes, which type? Type I - insulin dependent (insulin injections only)
Type II - non-insulin dependent (diabetic pills)
Type II - insulin dependent (diabetic pills and insulin)

Are you under the care of a physician for diabetes? Yes No

Is your blood sugar level monitored? Yes No If so, by whom? myself physician other

Do you take medication specifically for diabetes? Yes No If so, list: _____

Do you tend to be hypoglycemic (low blood sugar)? Yes No

Cardiovascular Function:

Have you had any of these cardiovascular events?

- Heart Attack? Yes No If yes, when: _____
- Stroke? Yes No If yes, when: _____
- Aneurysm? Yes No If yes, when: _____
- Heart By-Pass? Yes No If yes, when: _____
- Stent Surgery? Yes No If yes, when: _____
- Cardiac Arrhythmia? Yes No If yes, when: _____
- Pace Maker? Yes No If yes, when: _____

Are you under the care of a physician for any cardiovascular condition? Yes No

Do you take medication specifically for cardiovascular conditions? Yes No If so, list: _____

Have you been diagnosed with Congestive Heart Failure (CHF)? Yes No

Hypertension:

Do you have high blood pressure? Yes No

Do you have your blood pressure checked? Yes No

Are you under the care of a physician for hypertension (high blood pressure)? Yes No

Do you take medication specifically for hypertension? Yes No If so, list: _____

Kidney Function:

Have you been diagnosed with kidney disease? Yes No

Are you under the care of a physician for kidney problems? Yes No

Do you take medication specifically for kidney problems? Yes No If so, list: _____

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 so, specify: _____

Are you under the care of a physician for liver problems? Yes No

Do you take medication specifically for liver problems? Yes No If so, list: _____

Colon Function:

Do you have any of the following?

- Irritable Bowel? Yes No
- Colitis? Yes No
- Diarrhea? Yes No
- Diverticulitis? Yes No
- Crohn’s disease? Yes No
- Constipation? Yes No

Are you under the care of a physician for any colon problems? Yes No

Do you take medication specifically for colon problems? Yes No If so, list: _____

Stomach/Digestive Function:

Do you have any of the following?

- Acid Reflux? Yes No
- Gastric Ulcer? Yes No
- Heartburn? Yes No
- Celiac Disease? Yes No

Are you under the care of a physician for any stomach or digestive problems? Yes No

Do you take medication specifically for digestive problems? Yes No If so, list: _____

Ovarian/Breast Function:

Are you currently experiencing any of the following?

- | | | | |
|----------------------|--|------------------|--|
| Irregular Periods? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Painful Periods? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Menopause? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Amenorrhea? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hysterectomy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Uterine Fibroma? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fibrocystic Breasts? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heavy Periods? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Uterine Cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast Cancer? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are you under the care of a physician for any female problems? Yes No

Do you take medication specifically for female problems? Yes No If so, list: _____

Are you currently on Birth Control Pills? Yes No Date of Last menstrual cycle: _____

Thyroid Function:

Do you have thyroid problems? Yes No If so, specify: _____

Are you under the care of a physician for thyroid problems? Yes No

Do you take medication specifically for thyroid problems? Yes No If so, list: _____

Emotional Evaluation:

Do any of the following apply to you?

- Depression? Yes No
- Anxiety? Yes No
- Panic Attacks? Yes No
- Bulimia? Yes No
- Anorexia? Yes No

Are you under the care of a physician for any emotional problems? Yes No

Do you take LITHIUM? Yes No (If yes, you are prohibited from the Ideal Protein protocol.)

Do you take medication specifically for emotional problems? Yes No If so, list: _____

Inflammatory Conditions:

Do any of the following apply to you?

- | | | | |
|-----------------|--|---------------------------|--|
| Migraines? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fibromyalgia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Osteoarthritis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Fatigue Syndrome? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psoriasis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Other autoimmune or inflammatory condition: _____

Are you under the care of a physician for any inflammatory conditions? Yes No

Do you take medication specifically for inflammation? Yes No If so, list: _____

Allergies:

Do you have any **food** allergies? Yes No If so, list: _____

Do you have any **medication** allergies? Yes No If so, list: _____

Supplements:

Do you currently take any vitamins, herbs or other nutritional supplements? Yes No If so, list below:

- | | |
|----------|---------------|
| 1. _____ | Reason: _____ |
| 2. _____ | Reason: _____ |
| 3. _____ | Reason: _____ |
| 4. _____ | Reason: _____ |

Social History:

Do you prefer: Sweet foods Salty foods Fatty foods

Are you a vegetarian? Yes No If yes, are you a strict vegan? Yes No

How many glasses of **water** do you drink per day? _____ Cups of **coffee** per day? _____

Do you **smoke**? Yes No If yes, how many pack per day? _____ for how many years? _____

Do you drink **alcohol**? Yes No If yes, what, how much, how often? _____

Eating Habits: *(Please be as honest as possible so that we may better help you.)*

Breakfast every morning? Yes Sometimes Never Approximate Time: _____

Examples: _____

Snack before lunch? Yes Sometimes Never Approximate Time: _____

Examples: _____

Lunch every day? Yes Sometimes Never Approximate Time: _____

Examples: _____

Snack before dinner? Yes Sometimes Never Approximate Time: _____

Examples: _____

Dinner every evening? Yes Sometimes Never Approximate Time: _____

Examples: _____

Snack at night? Yes Sometimes Never Approximate Time: _____

Examples: _____

CASH Scale: **(Cravings / Appetite / Satiety / Hunger)**

Cravings (Compulsions) – Feeling or urge to eat when not hungry, when you are full and/or when there is no food in sight. You get a craving or urge to eat which cannot be repressed. *(Rate on 0-10 scale your frequency of food cravings.)*

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

Appetite – Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room and there is food everywhere. It looks and smells good. Everyone is having fun. What would you do? *(Rate on 0-10 scale your ability for appetite control.)*

0 1 2 3 4 5 6 7 8 9 10
Never eat more Always eat more

Satiety – A feeling of fullness acquired by eating. When you eat, you usually: *(Rate on 0-10 scale your typical eating habit in regards to feeling full.)*

0 1 2 3 4 5 6 7 8 9 10
Leave food on plate / One plate only / Go for seconds / Go for thirds

Hunger – That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort. *(Rate on 0-10 scale your level of hunger.)*

0 1 2 3 4 5 6 7 8 9 10
Never hungry Constantly hungry

INFORMED CONSENT for Participating in the Ideal Protein Weight Loss Method:

ABSOLUTE CONTRA-INDICATIONS TO PARTICIPATION:

No potential dieter is to be placed on the Ideal Protein Protocol with a history of or current diagnosis of the following conditions without written consent from his/her primary medical care physician or specialist monitoring this patient.

- History of a cardiovascular event such as a heart attack, stroke, aneurysm, by-pass, stent surgery, history of having cardiac arrhythmia including having a pace-maker
- History of or current active cancer, including skin cancers
- Pregnant female (note from OB/GYN ONLY is required before participation)
- Breast-feeding female (note from PEDIATRICIAN ONLY is required before participation)

NOT PERMISSIBLE ON THE PROTOCOL:

No potential dieter is to be placed on the Ideal Protein Weight Loss Protocol WITH OR WITHOUT the consent of his/her primary medical care provider or specialist monitoring this patient.

- Severe Liver Disease
- Severe Kidney Disease
- Diagnosis or history of Congestive Heart Failure (CHF)
- Patients currently on Lithium Therapy
- Patients with a diagnosis of Parkinson's Disease
- Strict Vegan lifestyle

You must take the recommended vitamins and minerals while you are on the Ideal Protein Weight Loss Method. If you stop taking them, you may experience undesirable side effects. I acknowledge this potential risk by initialing here. (client's initials) _____

If you are taking medications, are you interested in getting off of any or all of your prescription medications? (It will be the responsibility of the prescribing medical physician or your current primary physician to monitor, reduce and/or withdraw your medication dosage.) Yes No

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

By signing below, you (the dieting client) are stating the following: "I testify that none of the preceding contra-indicating criteria apply to me. I hereby recognize the accuracy and truthfulness of the information provided herein and that I have made the informed decision to begin the Ideal Protein Weight Loss Method.

Signature: _____

Date: _____