Ideal Body Image and Weight Loss

Health Profile

Date: _____

A 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. 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

Overall (Please use print characters)

First name: _____ Last name: _____

Address: _____ Apt./unit:

City: _____ State: _____ Zip code: _____

Phone: _____ Mobile: _____

Email: _____

Date of birth: _____ **Age**: _____

Profession: _____

How did you hear about us? ☐ Internet ☐ Referral ☐ Advertisement

How would you prefer to be contacted? ☐ Email ☐ Text – Cell Phone Provider: _____

Current weight: _____ Height: _____

What is your marital status? ☐ Married ☐ Single ☐ Widow ☐ Divorce ☐ Other:

How many children do you have? _____ How old are they? _____

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

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: _____ Last visit: _____

Dr. _____ Specialty: _____

Patient since: _____ Last visit: _____

Do you Smoke? ☐ Yes ☐ No

If so, how many per day? _____

For how many years? _____

Do you drink Alcohol? ☐ Yes ☐ No

If so, how often? ☐ Daily ☐ Weekly ☐ Occasionally

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 WEIGHT LOSS'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)
- ☐ Pace Maker (NPC) Year:_____
- ☐ 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)

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
- ☐ Crohn's Disease
- ☐ Diarrhea

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

_____

_____

7. Ovarian/Breast Function ☐ N/A

Do you currently have any of the following conditions:

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

8. 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

If so, please specify:

9. Neurological/Emotional Function ☐ N/A

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: _____

10. 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?

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. Do you have any of the following ☐ N/A

- ☐ Blood disorder
- ☐ Herpes (cold sores)
- ☐ Hirsutism
- ☐ Hormonal Imbalance
- ☐ Acne
- ☐ Vitiligo
- ☐ Melasma
- ☐ Port Wine Stain
- ☐ Psoriasis
- ☐ Shingles
- ☐ Skin Pigmentation
- ☐ Melanoma
- ☐ Keloid Scars
- ☐ Other: _____

14. Allergies ☐ N/A

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

If yes, please specify:

15. I am interested in: (Please check all that apply)

☐ Botox/Dysport	☐ Sun Damage treatment
☐ Filler	☐ Fat Reduction
☐ Acne Treatments	☐ Skin Tightening
☐ Fine Lines/wrinkles treatment	☐ Tattoo Removal
☐ Skin Care Advice/Products	☐ Hormonal Therapy Replacement Therapy
☐ Hair Removal	☐ Facial/Leg Vein Treatments
☐ Vaginal Rejuvenation	☐ Cellulite Reduction
☐ Erectile Dysfunction treatments	☐ Weight Loss
☐ Body Contouring	☐ Peptides
☐ Rosacea	☐ Physical Therapy
☐ Eye Bag Reduction	☐ Melasma

If interested in other, please specify below:

16. Additional Questions:

Are you currently being treated for any conditions not listed? If yes, please specify.

Have you ever used (or are currently using) Retin A or Glycolic Acid? If yes, please specify.

Have you ever used (or are currently using) Accutane? If yes, please specify.

Have you ever had a chemical peel? If yes, please specify.

What products are you currently using on your skin?

Have you had any laser treatments? If yes, please specify.
Do you have any acrylic or dental implants, crowns, or bridgework? If yes, please specify.
Do you have any Tattoos or permanent makeup? If yes, please specify.
Do you sunbathe or use self-tanning lotions or use tanning beds? If so, how often?
Have you ever had filler or Botox/Dysport injections in the area to be treated? If yes, please specify.
Do you have any skin sensitivities?

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE: _____ DATE: _____

17. 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.

18. Weight Loss (Only fill out if interested in weight loss program)

(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

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 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.)

_____

_____

Who does the most cooking at home?

_____

_____

What are your reasons for starting this protocol?

_____

_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight with Ideal Weight Loss's professionally supervised protocol: (circle one)

Least important 1 2 3 4 5 6 7 8 9 10 Very important