



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 weight loss method: (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? _____

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



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 a Sodium-Glucose Co-Transporter inhibitor (SGLT-2), do not start the weight loss method.

3. Cardiovascular Function N/A

Have you had any of the following conditions?

<input type="checkbox"/> Arrhythmia (NPA)	<input type="checkbox"/> Hyperkalemia (High potassium) (NPA)
<input type="checkbox"/> Blood Clot (NPA)	<input type="checkbox"/> Hypokalemia (Low potassium) (NPA)
<input type="checkbox"/> Coronary Artery Disease (NPA)	<input type="checkbox"/> Hypertension (High blood pressure) (NPA)
<input type="checkbox"/> Heart attack (NPC)	<input type="checkbox"/> Pulmonary Embolism (NPA)
<input type="checkbox"/> Heart Valve Problem (NPA)	<input type="checkbox"/> Stroke or Transient Ischemic Attack (NPA)
<input type="checkbox"/> Heart Valve Replacement (porcine/mechanical) (NPA)	<input type="checkbox"/> Congestive Heart Failure (NPC)
<input type="checkbox"/> Hyperlipidemia (High cholesterol/triglycerides)	Please select one (if applicable):
	<input type="checkbox"/> History of Congestive Heart Failure
	<input type="checkbox"/> Current Congestive Heart Failure (NPC)

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



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:

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



7. Digestive Function N/A

Do you have any of the following conditions:

- | | |
|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Gluten intolerance |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Gastric Ulcer (NPA) | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> 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

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



10. Neurological/Emotional Function N/A

Do you have any of the following conditions:

<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Anorexia (History of)	<input type="checkbox"/> Epilepsy (NPA)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Bulimia (History of)	<input type="checkbox"/> Schizophrenia

Other issues: _____

11. Inflammatory Conditions N/A

Do you have any of the following conditions:

<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Lupus	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Migraines	<input type="checkbox"/> Rheumatoid
<input type="checkbox"/> Other autoimmune or inflammatory condition	

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: _____

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



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: _____

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



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.

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



Confirmation of full health status disclosure by the client and agreement to arbitrate disputes

I confirm that the information that I have provided 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™ Weight Loss Method 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™ Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Ideal Protein™ Weight Loss Method, 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 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, its parent companies, subsidiaries and affiliates and their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the **"Releases"**) 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 Releases 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 province 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:	_____
Name of client (print)	_____
_____	_____
Name and title	Signature

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

Informed Consent for Weight Control Program for The Devine Touch

Consent to participate

I hereby consent to act as a participant in a weight control program involving the use of Ideal Protein foods and supplements. I understand that various coaches of The Devine Touch may provide this to me.

I have been informed that the benefits and value of this method are only guaranteed if the protocol is followed as set out from Ideal Protein. Ideal Protein insists that you make a commitment to this program before we accept you as a client. We want you to be healthier and lose weight, but first you must have the desire to do so. There will be no negotiations: Results on the Protocol are predictable and repeatable, which represents the gold standard in scientific medicine. We feel passionately that we cannot fulfill our promise to you if you do not strictly adhere to our Protocol. We have developed these guidelines for Ideal Protein participants.

We can only effectively coach you to RESULTS if you:

*Follow the Ideal Protein Protocol EXACTLY. All required supplements as stated on my Phase 1,2 or 3 sheet must be taken each day.

*Journal your daily intake of food, fluids & supplements. BRING YOUR JOURNAL TO ALL WEEKLY CONSULTATIONS.

*Maintain your weekly appointments with your Ideal Protein Coach.

*Don't Cheat!!

I understand that I have the right to discontinue after I have begun and that there are no refunds on administrative fees, opened supplements or Ideal Protein food products. I understand that I have the right to ask questions and to know the purpose and objectives of my treatment program. I understand that I must remain compliant with the rules set out by my coach in conjunction with Ideal Protein protocol and method. That my coach(s) will work with me to help me to stay compliant to the best of their ability.

Having read this page, I hereby consent to this program. I have had adequate time to ask any questions and understand the answers provided. Any future questions may be posed and will be responded to in a timely fashion.

To fully protect my health during my weight loss, it is the policy of The Devine Touch that my Ideal Protein meal replacements & required Natura Supplements must be purchased through this location to stay qualified. I have been advised that there is poor quality, imitation and expired Ideal Protein meal replacements on the market that are NOT IP approved. Therefore, to fully protect my health and stay compliant with the protocol, I understand that all meal replacements must be purchased through this location while on this protocol. I understand that risk of disqualification will ensue if adherence is broken.

I also understand that all information that is given to The Devine Touch by me is HIPPA related and no information will be shared or sent to another clinic without the approval of me. Even though this is NOT a medical practice, this office will adhere to my rights of privacy.

Disclaimer- all Ideal Protein products are subject to formulation changes at any time. I must always reference the box or packet for exact ingredients

Dieter Name _____

Dieter Signature _____ Date _____

Weight Coach Signature _____ Date _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient making authorization:

Full Name:	
Birth Date (MM/DD/YYYY):	Phone Number:
Address:	

Healthcare provider or entity authorized to disclose this information:

Clinic/Provider Name: The Devine Touch Inc	
Phone Number: (401) 315-2405	Fax Number: (401) 315-2405
Address: 4 High St Westerly, RI 02891	

Healthcare provider or entity authorized to use this information:

Clinic/Provider Name:	
Phone Number:	Fax Number:
Address:	

Specific information to be disclosed (check one):

<input type="checkbox"/> Biometric Data readings from Tanita Scale while on the Ideal Protein Weight Loss Method <small>(enter as MM/DD/YYYY):</small>

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:	
Witness (optional):	Date:

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:
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