12189 W. 64th Ave Ste 102
Arvada, CO 80004
303-424-9549
www.arvadasportandspine.com

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 guide his or her weight-loss plan. A client may be advised to seek medical advice based on his or her health profile.

Legal Name: First: _____ Middle Initial: ___ Last: _____Preferred Name:_____

Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: _____ Email **(required)**: _____

Marital Status: M S D W Spouse Name:_____ Number of Children:_____Ages:_____

Employment Status: Employed Full time student Part time student Other Employer: _____

Work Phone: _____ Job Title:_____ Type of Work:_____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Whom may we thank for referring you?_____

Primary Care Physician **(required)**:_____

Primary Care Physician Address or Phone #:_____

I give Arvada Sport and Spine Group my permission to communicate my progress to my primary care physician: □ Yes □ No

Please list additional physicians you see and their specialty_____

_____

Medical Information

Height: _____ Current Weight: _____lbs. Weight 1 year ago: _____ lbs.
Min. Adult Weight:_____ lbs at age _____ Maximum Weight: _____ lbs. at age _____
Do you exercise? □ Yes □ No
If yes, what kind? _____
How often?_____

Have you been on a diet before? □ 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, etc.): _____
_____

On a scale of 1 to 10, circle what level of importance you give to losing weight via Ideal Protein's professionally supervised weight loss method (10 being the most important): 1 2 3 4 5 6 7 8 9 10

***Diabetes*:**
Do you have diabetes? □ Yes □ No (if no, skip to next section)
If so, are you under the care of a physician? □ Yes □ No
If so, 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, by whom? □ Myself □ Physician □ Other (specify): _____
Are you taking any medication? □ Yes □ No
If so, please list:_____
Do you tend to be hypoglycemic? □ Yes □ No

***Cardiovascular Function*:**
Have you had a cardiovascular event? □ Yes □ No (if no, skip to next section)
If so, please specify:

_____

How long ago?_____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list: _____
Do you have a history of arrhythmia □ Yes □ No
Have you been diagnosed with Congestive Heart Failure (CHF) □ Yes □ No

***Hypertension*:**
Do you have high blood pressure? □ Yes □ No (if no, skip to next section)
If so, do you have your blood pressure checked? □ Yes □ No
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:_____

Kidney Function:
Have you been diagnosed with kidney disease? □ Yes □ No
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please 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 no, skip to next section)
If so, please specify:

_____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:

_____

***Colon Function*:**
Do you have: □ Irritable Bowel □ Colitis □ Diarrhea □ Diverticulosis?
□ Crohn's disease □ Constipation
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:_____

***Stomach/Digestive Function*:**
Do you have: □ Acid Reflux □ Gastric Ulcer □ Heartburn □ Celiac Disease?
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:_____

Ovarian/Breast Function:
Check off the situations that apply to you currently:
□ Irregular Periods □ Menopause □ Fibrocystic Breasts □ Painful Periods □ Hysterectomy
□ Heavy periods □ Amenorrhea □ Uterine Fibroma □ Cancer (uterus, breast)
If so, are you under the care of a physician? □ Yes □ No
Are you taking birth control pills? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:_____
Please initial that you understand that the process of weight loss may decrease the effectiveness of hormonal contraceptives, and additional birth control measures may need to be used while on any weight loss program. _____

Please indicate the date of your last menstrual cycle:_____

***Thyroid Function*:**
Do you have thyroid problems? □ Yes □ No (if no, skip to next section)
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:_____

***Emotional Evaluation*:**
Do any of the following apply to you? (if no, skip to next section)
□ Depression □ Anxiety □ Panic Attacks
□ Bulimia (or history of) □ Anorexia (or history of)
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list:_____

***Inflammatory Conditions*:**
Do any of the following apply to you? (if no, skip to next section)
□ Migraines □ Fibromyalgia □ Rheumatoid Arthritis □ Lupus
□ Osteoarthritis
□ Chronic Fatigue Syndrome □ Psoriasis
□ Other autoimmune or inflammatory condition:_____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No

If so, please list:_____

***General*:**
Do you have Parkinson's disease? □ Yes □ No
Do you have Cancer? □ Yes □ No
Are you in Cancer remission? □ Yes □ No
If so, please specify and indicate for how long: _____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any medication? □ Yes □ No
If so, please list: _____
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
Do you have other health problems? □ Yes □ No
If so, please specify: _____
If so, are you under the care of a physician? □ Yes □ No
Are you taking any other medications not listed above? □ Yes □ No
If so, please list: _____
Are you currently taking Vitamins, Herbs or Supplements? □ Yes □ No
Vitamin, Herb or Supplement Name, Reason, & Amount
1. _____
2. _____
3. _____
4. _____
5. _____

***Allergies*:**
Do you have any **food** allergies? □ Yes □ No

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

If so, please list:_____

Contraindication Summary

- Severe Kidney Disease
- Severe Liver Disease
- Congestive Heart Failure
- Active Cancer
- History of unstable Arrhythmia
- Cardiac/Cardiovascular Event (within the last 6 months)
- Pregnancy
- Breastfeeding
- Strict Vegan Lifestyle
- Parkinson's Disease
- Patients currently on Lithium therapy

You must take the required Ideal Protein vitamins and minerals while you are on the Ideal Protein Weight-Loss Method. If you stop taking them, you may experience undesirable side effects. _____ (Client's initials)

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

Signature: _____ Date: _____
The signatory client hereby recognizes the veracity of the information provided herein, and that he/she has made an informed decision to go on the Ideal Protein Weight Loss Method.