



12189 W. 64th Ave Ste 102  
 Arvada, CO 80004  
 303-424-9549  
[www.arvadasportandspine.com](http://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.