

Health Profile

Billings Last Diet 10 Avanta Way Suite 2 Billings, MT 59102 (406) 294-6751 www.BillingsLastDiet.com

Dietary consultation involves a health profile which 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.

<u>General</u>				
Last Name:		First Name:		
Address:		/	Apt/Unit: #	
City:		State:	Zip:	
Phone:	Cell:		E-mail: _	
Date of Birth:	Age:	Profession:		
Whom may we thank for referring y	ou?			
Weight:lbs. Weight 1 year ago Maximum Weight: lbs. at ag		_		at age
Do you exercise? Yes No If yes, what kind?				
How often?				
Have you been on a diet before? If yes, please specify which diet and too much cooking involved, etc.):	d why yo	u think it didn't w	ork for you (

On a scale of 1 to 10, indicate what level of importance you give to losing weight via Ideal Protein's professionally supervised weight loss method (10 being the most important):

<u>Family Life</u> :	
What is your marital status? M S D W Other Number of children: Ages:	•
<u>Medical Information</u> :	
Please list any physicians you see and their specia	Ity:
<u>Diabetes</u> :	
Do you have diabetes? $\ \ \square$ Yes $\ \ \square$ No (if no, skip to	next section)
If so, are you under the care of a physician? $\ \ \Box$ Ye	es 🗆 No
If so, which type?	
□ Type I – insulin dependent (insulin inj	ections only)
□ Type II – non-insulin dependent (diabe	etic pills)
$\ \square$ Type II – insulin dependent (diabetic $\mathfrak p$	•
Is your blood sugar level monitored? Yes N If so, by whom? Myself Physician Other	
Are you taking any medication? Yes No If so, please list:	
Do you tend to be hypoglycemic?	s □ No
<u>Cardiovascular Function</u> :	
	S □ No (if no, skip to next section)
How long ago?	
If so, are you under the care of a physician? □ Yes	S 🗆 No
Are you taking any medication? ☐ Yes If so, please list:	s □ No
Do you have a history of arrhythmia	 s □ No
Have you been diagnosed with Congestive Heart F	ailure (CHF) 🗆 Yes 🗆 No
<u>Hypertension</u> :	
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? If so, please list:	□ Yes □ No

Have you been diagnosed with kidney disease? If so, are you under the care of a physician? Are you taking any medication? If so, please list:	□ Yes □ No □ Yes □ No □ Yes □ No	
Have you ever had Kidney Stones?	□ Yes □ No	
Have you ever had Gout?	□ Yes □ No	
Liver Function:		
Do you have liver problems? If so, please specify:	\square Yes \square No (if no, skip to next section)	
If so, are you under the care of a physician?	□ Yes □ No	
Are you taking any medication? If so, please list:	□ Yes □ No	
,	 Diarrhea Diverticulitis Constipation? Yes No Yes No 	
Stomach/Digestive Function: Do you have: Acid Reflux Gastric Ulcer If so, are you under the care of a physician? Are you taking any medication? If so, please list:	□ Heartburn □ Celiac Disease? □ Yes □ No □ Yes □ No	
Ovarian/Breast Function: Check off the situations that apply to you currer Irregular Periods	Fibrocystic Breasts	
Please indicate the date of your last menstrual of	cycle:	

Thyrola Function:					
Do you have thyroid problems?		□ Yes	□ No (if no, skip	to next	section)
If so, are you under the care of a ph	ysician?	□ Yes	□ No		
Are you taking any medication?		□ Yes	□ No		
If so, please list:					
Emotional Evaluation:					
Do any of the following apply to you?			ction)		
□ Depression □ Anxiety	□ Panic Atta		6)		
, ,	□ Anorexia	•	, ,		
If so, are you under the care of a ph	-	□ Yes □			
Are you taking any medication?		□ Yes □	□ INO		
If so, please list:					
Inflammatow. Conditions.					
<u>Inflammatory Conditions</u> :	.				
Do any of the following apply to you					
□ Migraines □ Fibromyalgia □ F	Rheumatoid Ai	rthritis	□ Lupus		
Osteoarthritis Chronic Entique Syndrome Totalia Entique Syndrome	Dooringia				
□ Chronic Fatigue Syndrome□ Other autoimmune or inflammatory					
Utilei autoiiiiiiule oi iiiilaiiiilatoi	y condition.				
The same way was also also also also also also also al		V	N		
If so, are you under the care of a ph	•	□ Yes : □ Yes :			
Are you taking any medication? If so, please list:		u res l	」 INO		
11 30, piedse list.					
General:					
<u> </u>		.,			
Do you have Parkinson's disease?		□ Yes			
Do you have Cancer?		□ Yes			
Are you in Cancer remission?		□ Yes	□ No		
If so, please specify and indicate for	_				
If so, are you under the care of a ph	ysician?		□ No		
Are you taking any medication?		□ Yes	□ No		
If so, please list:					
Are you generally fatigued or have lo	ow energy?	□ Yes	□ No		
Are you generally ladigated or have to	ow chargy.	□ 1C3	110		
Are you pregnant?	o Are vo	u breast	feeding?	□ Yes	□ No
	, .				
Do you get cold easily? □ Yes □ N	lo Do you l	have col	d 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 ph		_		□ Yes	□ No
Are you taking any other medications	s not listed ab	ove?		□ Yes	□ No
If so, please list:					

Are you currently taking Vitamins, Herbs vitamin, Herb or Supplement	nt Name Reason
1	
3	
4	
J	
<u>Allergies</u> :	
Do you have any food allergies?	□ Yes □ No
If so, please list:	
Do you have any medication allergies? If so, please list:	□ Yes □ No
Eating Habits: (please be as honest as	nossible so that we may better belo you)
Breakfast	possible so that we may better help your
Do you have breakfast every morning?	□ Yes □ Sometimes □ Never
Approximate Time:	
Examples:	
Do you have a small hafara lunch?	- Vos - Cometimos - Novem
Do you have a snack before lunch? Approximate Time:	
	.
Lunch	
Do you have lunch every day?	□ Yes □ Sometimes □ Never
Approximate Time:	
Examples:	
Do you have a snack before dinner?	□ Yes □ Sometimes □ Never
Approximate Time:	
Examples:	
Dinner	
Do you have dinner every day?	□ Yes □ Sometimes □ Never
Approximate Time: Examples:	-
Do you got a speak at sight?	- Voc - Complimed Nove
Do you eat a snack at night? Approximate Time:	□ Yes □ Sometimes □ Never
	-

Do you prefer: Sweet foods Salty foods Fatty foods Yes No
How many glasses of water do you drink per day? glasses
How many cups of <u>coffee</u> do you drink per day? cups Do you \underline{smoke} ? \Box Yes \Box No
If yes, how many packs per day? for how many yrs?
Do you drink <u>alcohol</u> ?
If yes, what, how much, and how often?
CASH Scale: Compulsions or Cravings/Appetite/Satiety/Hunger Score each item on a $0-10$ numbering scale. Each feeling represents a different part of the brain and different neurotransmitters
<u>Compulsions/Cravings</u>
Feeling or urge to eat when not hungry. You are full. There is no food in sight. You get an urge to eat which cannot be repressed.
012345678910
Never occurs Constant
<u>Appetite</u>
Feeling of hunger stimulated by sight, sounds, smells, or social cues. You recently ate and feel full. You walk into a room. There is food everywhere. It looks and smells good. Everyone is having fun. You:
012345678910
Never eat more Always eat more
<u>Satiety</u>
A feeling of fullness acquired during eating. When you eat, you usually:
012345678910
Leave food on plate one plate only second's thirds
<u>Hunger</u>
That feeling of a pain or ache in your stomach when really empty. This is a true pain or discomfort

Loss Method. If you stop taking them, yo effects (Client's initials)	9
If you have health problems not indicated o your physician.	n this health profile, please consult
Signature:	Date:

Value must take vitamine and minerals while you are on the Ideal Dretain Weight

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.

*Disclaimer:

A history of **Congestive Heart Failure (CHF)**, **Atrial Fibrillation**, **Parkinson's disease** or **Lithium prescription** are **ABSOLUTE CONTRAINDICATIONS** to the Ideal Protein Weight Loss Method, regular or alternative. No non-medical Ideal Protein Clinic may ever accept such a person as a dieter. The only exceptions are **licensed medical doctors** (MD or DO). These practitioners may accept such patients, if in their professional judgment our protocol would be a benefit to their health. By accepting such a dieter, the physician will assume all responsibility for this patient's health as per their medical license.