

## Health Profile

Initial Consultation Date/Time: \_\_\_\_\_

Dietary consultation involves a health profile. The purpose of the health profile is not to establish a diagnosis but rather to determine your health status in order to guide your weight loss. We highly recommend you consult with your physician prior to starting any weight loss plan.

### Legend (For clinic use)

**NPA** – Needs Physician Approval

### Overall (please print clearly)

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_

Profession: \_\_\_\_\_

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

How many children do you have \_\_\_\_\_ What are their ages?: \_\_\_\_\_

Who does most of the cooking at home?: \_\_\_\_\_

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

**Referral Source (How did you hear about us?):** \_\_\_\_\_

Current Weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ Minimum adult weight: \_\_\_\_\_ At age: \_\_\_\_\_

Do you exercise:  Yes  No If yes, what kind? \_\_\_\_\_

How often do you exercise?  Daily  Weekly  Other \_\_\_\_\_

Have you ever been on a diet before?:  Yes  No  
 If yes, specify which diet(s) and why you think they did not work for you (i.e. too rigid, too much cooking, etc.)  
 \_\_\_\_\_

**On a scale of 1 to 10, circle how important is it for you to lose weight and get healthy?**  
 Least important    1    2    3    4    5    6    7    8    9    10    Very Important

**Why do you want to lose weight?** \_\_\_\_\_

### FOR CLINIC USE ONLY:

<b>START WEIGHT:</b>	<b>GOAL WEIGHT:</b>
<b>DIET START DATE:</b>	<b>GOAL DATE:</b> @                      /week
<b>3-DAY F/U DATE:</b>	<b>NOTES:</b>
<b>PHYSICIAN CONSENT REQUIRED:</b> YES    NO	<b>PHYSICIAN CONSENT FAXED:</b> YES    NO
<b>PERCENTAGES:</b> 10--                      20--                      30--                      40--                      50--	

Client last/first name: \_\_\_\_\_ Page 1

<b>PHYSICIANS:</b>	Reviewed: <input type="checkbox"/>
<p><b>Who is your primary care physician?:</b> _____</p> <p>Please list any other physicians who treat you and their specialty:</p> <p>Physician name: _____ Specialty: _____</p> <p>Physician name: _____ Specialty: _____</p> <p>Physician name: _____ Specialty: _____</p> <p>Physician name: _____ Specialty: _____</p>	

<b>DIABETES:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
<p>Do you have diabetes:    <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>If no, please skip to next section</i></p> <p>If yes, which type:        <input type="checkbox"/> Type 1—Insulin dependent (insulin injections only)—<b>ALTERNATIVE PROTOCOL ONLY</b></p> <p style="padding-left: 100px;"><input type="checkbox"/> Type 2—Insulin dependent (diabetic pills, and/or insulin injections)</p> <p>Is your blood sugar monitored? <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, how often?: _____</p> <p>If so, by whom?:            <input type="checkbox"/> Myself    <input type="checkbox"/> Physician    <input type="checkbox"/> Other _____</p> <p>Do you tend to be hypoglycemic?: <input type="checkbox"/> Yes    <input type="checkbox"/> No    <i>If yes, please inquire about our alternative protocol.</i></p> <p><b>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 THE REGULAR PROTOCOL. Please speak to your coach about our Alternative Protocol.</b></p>	

<b>CARDIOVASCULAR FUNCTION:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>		
<p>Do you or have you had any of the following conditions?:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding-right: 20px;"> <input type="checkbox"/> Arrythmia <b>(NPA)</b>  <input type="checkbox"/> Blood clot <b>(NPA)</b>  <input type="checkbox"/> Coronary artery disease <b>(NPA)</b>  <input type="checkbox"/> Heart attack <b>(NPC)—Must be 6 months post</b>  <input type="checkbox"/> Heart valve problem <b>(NPA)</b>  <input type="checkbox"/> Heart valve replacement <b>(NPA)</b>  <input type="checkbox"/> Hyperlipidemia              (high cholesterol/triglycerides)             </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Hyperkalemia (high potassium) <b>(NPA)</b>  <input type="checkbox"/> Hypokalemia (low potassium) <b>(NPA)</b>  <input type="checkbox"/> Hypertension (high blood pressure) <b>(NPA)</b>  <input type="checkbox"/> Pulmonary embolism <b>(NPA)</b>  <input type="checkbox"/> Stroke or transient ischemic attack <b>(NPA)</b>  <input type="checkbox"/> Congestive heart failure <b>(NPA)</b>  <input type="checkbox"/> Please select one (if applicable)  <input type="checkbox"/> History of congestive heart failure  <input type="checkbox"/> Current congestive heart failure             </td> </tr> </table> <p>If you answered yes to any of the above, please give <b>all</b> dates of occurrence and current status:          _____</p> <p>Have you ever had any type of heart surgery?    <input type="checkbox"/> Yes    <input type="checkbox"/> No          If yes, what type and when?: _____</p>		<input type="checkbox"/> Arrythmia <b>(NPA)</b> <input type="checkbox"/> Blood clot <b>(NPA)</b> <input type="checkbox"/> Coronary artery disease <b>(NPA)</b> <input type="checkbox"/> Heart attack <b>(NPC)—Must be 6 months post</b> <input type="checkbox"/> Heart valve problem <b>(NPA)</b> <input type="checkbox"/> Heart valve replacement <b>(NPA)</b> <input type="checkbox"/> Hyperlipidemia (high cholesterol/triglycerides)	<input type="checkbox"/> Hyperkalemia (high potassium) <b>(NPA)</b> <input type="checkbox"/> Hypokalemia (low potassium) <b>(NPA)</b> <input type="checkbox"/> Hypertension (high blood pressure) <b>(NPA)</b> <input type="checkbox"/> Pulmonary embolism <b>(NPA)</b> <input type="checkbox"/> Stroke or transient ischemic attack <b>(NPA)</b> <input type="checkbox"/> Congestive heart failure <b>(NPA)</b> <input type="checkbox"/> Please select one (if applicable) <input type="checkbox"/> History of congestive heart failure <input type="checkbox"/> Current congestive heart failure
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<b>KIDNEY FUNCTION:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Have you had any of the following conditions?:	
<input type="checkbox"/> Kidney disease <b>(NPA)</b> <input type="checkbox"/> Kidney transplant <b>(NPA)</b> <input type="checkbox"/> Kidney stones— <b>Must drink 80-100oz water daily</b> <input type="checkbox"/> Do you presently or have you ever had gout? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, since when?: _____ If yes, what medication has been prescribed?: _____ If you answered yes to any of the above, please give <b>all</b> dates of occurrence and current status: _____	

<b>LIVER FUNCTION:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Have you ever had any liver conditions?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you answered yes to the above, please give <b>all</b> dates of occurrence and current status: _____ _____	

<b>COLON FUNCTION:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Do you have any of the following conditions:	
<input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Diarrhea <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Ulcerative colitis  If you answered yes to the above, please give <b>all</b> dates of occurrence and current status: _____ _____	

<b>DIGESTIVE FUNCTION:</b> <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Do you have any of the following conditions:	
<input type="checkbox"/> Acid reflux <input type="checkbox"/> Celiac disease <input type="checkbox"/> Gastric ulcer <b>(NPA)</b> --If yes, is your ulcer healed? <input type="checkbox"/> Yes <input type="checkbox"/> <b>No—If no, cannot do diet</b> <input type="checkbox"/> Gluten intolerance <input type="checkbox"/> Heartburn <input type="checkbox"/> History of bariatric surgery <b>(NPA)</b> If yes, date and type of surgery and current status: _____ If you answered yes to the above, please give <b>all</b> dates of occurrence and current status: _____	

OVARIAN/BREAST FUNCTION: <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
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 or on any type of contraceptive birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If yes, <u>IMPORTANT</u>--Changes in estrogen levels may render birth control methods less effective.</b>	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, cannot do diet</b>
Are you breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, cannot do diet</b>

ENDOCRINE FUNCTION: <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Do you have thyroid problems?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify: _____	
Do you have para thyroid problems?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify: _____	
Do you have adrenal gland problems?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, specify: _____	
Have you been told you have Metabolic Syndrome?: <input type="checkbox"/> Yes <input type="checkbox"/> No	

NEUROLOGIC/EMOTIONAL FUNCTION: <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
Do you have any of the following conditions??	
<input type="checkbox"/> Alzheimer's disease— <b>Cannot do diet</b>	<input type="checkbox"/> Depression
<input type="checkbox"/> Anorexia (history of)	<input type="checkbox"/> Epilepsy--date of last seizure _____
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Bulimia (history of)	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Parkinson's ( <b>NPA</b> )
If yes, taking Lithium? <input type="checkbox"/> Yes	
<b>(NPA)— You must have your levels monitored by the doctor during weight loss.</b>	
<b>They may need to adjust the dosage. Very important!</b>	
<input type="checkbox"/> Other : _____	

INFLAMMATORY CONDITIONS: <input type="checkbox"/> N/A	Reviewed: <input type="checkbox"/>
<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 arthritis
<input type="checkbox"/> Other autoimmune or inflammatory condition: _____ _____	

CANCER:	Reviewed: <input type="checkbox"/>	
<b>Have you ever had cancer?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes (NPA)
What type and date of diagnosis?: _____		
<b>Do you have cancer now?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes— <b>Cannot do diet</b>
What type and date of diagnosis?: _____		
Is your cancer in remission?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, since when? _____		

GENERAL HEALTH:	Reviewed: <input type="checkbox"/>		
<b>Do you have sleep apnea?:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Since: _____
Do you have any other health conditions not discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please note: _____ _____			

FOOD ALLERGIES:	Reviewed: <input type="checkbox"/>		
<b>Do you have any food allergies or sensitivities?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify: _____			

**EATING HABITS: (Please provide very honest answers)**

Reviewed:

**BREAKFAST:**

Do you eat **breakfast** every morning?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you snack before lunch?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

**LUNCH:**

Do you eat **lunch** every day?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you snack before dinner?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

**DINNER:**

Do you eat **dinner** every day?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

Do you snack before bed?:  Yes  Sometimes  No  Never

Approximate time: \_\_\_\_\_

Examples: \_\_\_\_\_

**OTHER:**

Reviewed:

Are you a vegan?:  Yes  No *If yes, vegans do not qualify due too many dietary restrictions.*

Are you a vegetarian?:  Yes  No

Do you smoke?  Yes  No

If yes, how much and for how long? \_\_\_\_\_

**WATER**

How many 8oz. glasses of water do you drink daily?: \_\_\_\_\_

**COFFEE/TEA**

Do you drink coffee OR tea on a daily basis?:  Yes  No

If yes, how much coffee/tea do you drink per day and what size?: \_\_\_\_\_

What do you put in your coffee/tea?: \_\_\_\_\_

**SODA**

Do you drink any soda?  Yes  No

If yes, what kind, how many, and how often?: \_\_\_\_\_

***IMPORTANT: Please do not abruptly decrease soda consumption due to caffeine withdrawal. Decrease slowly and aim to discontinue altogether within a couple weeks.***

**JUICE**

Do you drink any juice?:  Yes  No

If yes, what kind, how many, and how often?: \_\_\_\_\_

**ALCOHOL**

Do you drink alcohol?:  Yes  No

If yes, what kind, how many, and how often?: \_\_\_\_\_

**IMPORTANT ABOUT ALCOHOL:** When the body is in a state of ketosis, the liver and kidneys are producing glucose to maintain proper blood sugar levels (gluconeogenesis). Alcohol can stop the production of sugar in the liver. This can lead to a potentially dangerous low blood sugar (hypoglycemia).

Thus, drinking alcohol while on this program can cause you to pass out without warning and possibly damage your brain.

Coaches initial that this disclaimer was read to the client: \_\_\_\_\_





## **CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES**

I confirm that the information that I have provided to The Diet Center Weight Loss Done Right (the "Clinic") and that is recorded by me on this 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 **in bold**/ identified as NPA on this form. Furthermore, I understand that I should not be undertaking or otherwise following the diet protocol 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 Diet Center Weight Loss Done Right protocol, ii) remain under the supervision of said medical doctor while I am on The Diet Center Weight Loss Done Right protocol and iii) provide documentation confirming the foregoing.

I understand that if 1) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, 2) have not disclosed same to the Clinic and iii) nevertheless chose to follow on The Diet Center Weight Loss Done Right protocol without specific supervision, such decision will be completely voluntary, and I, for myself and my successors, release and discharge the Clinic as well as The Diet Center Weight Loss Done Right, their parent companies, subsidiaries and affiliates and each of their respective shareholders, directors, employees, agents, representatives, successors and assigns (collectively, the "Releasees") 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 of following The Diet Center Weight Loss Done Right protocol.

I confirm that The Diet Center Weight Loss Done Right protocol has been explained to me, that I have had the opportunity to ask questions relating to The Diet Center Weight Loss Done Right protocol, that I have been provided with the answers to such questions, and that I understand the importance of strictly following The Diet Center Weight Loss Done Right protocol as explained to me verbally and in the materials provided to me, both before and during the period I will be following The Diet Center Weight Loss Done Right protocol.

Without limitation to the foregoing, I confirm that I have been advised that because The Diet Center Weight Loss Done Right protocol limits the ingestion of certain foods, it is mandatory that I consume the required vitamins and minerals while I am on The Diet Center Weight Loss Done Right protocol.

I undertake to disclose immediately to the Clinic and/or my physician any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am following The Diet Center Weight Loss Done Right protocol.

I specifically agree that all claims against any of the Releasees 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 state of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

**CONSENT AND AGREEMENT TO PARTICIPATE**

Due to our educational and knowledge-based dietary approach, we insist that you make a commitment to yourself and 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.

Results on our program are predictable and repeatable. We feel passionately that we cannot fulfill our promise to you if you do not strictly adhere to the Protocol. We have developed these guidelines for The Diet Center Weight Loss Done Right participants.

**We can only effectively coach you to results if you:**

- Follow the program ***EXACTLY*** as written making no customized modifications.
- Consume only The Diet Center Weight Loss Done Right products—Substitutions are not allowed.
- Take all ***MANDATORY*** supplements daily--Substitutions are not allowed and ***not taking the supplements could affect your health and SLOW DOWN YOUR WEIGHT LOSS.***
- Journal your daily intake of food, fluids, and supplements in either a paper journal or an app.
- Maintain your weekly appointments. See below regarding late cancellation/no show fees. ***Please notify us immediately if you need to change your appointment day/time.***
- Abstain from drinking alcohol. It is dangerous to drink alcohol while on this protocol.
- Don't cheat--This will only prolong your weight loss!
- To maintain your weight loss, ***it is strongly recommended to complete all phases*** and continue coming for at least one full year after reaching your goal weight.

**CONSENT TO PARTICIPATE**

- I agree to participate in The Diet Center Weight Loss Done Right's weight loss program using their food/supplements.
- I have been informed and understand that drinking alcohol while on the program is dangerous for my health and could result in serious injury. Therefore, I agree to abstain from drinking alcohol while on this weight loss protocol.
- I understand that I will be seen by various coaches throughout my weight loss journey.
- I have been informed that the possible benefit of this program is not guaranteed.
- I understand that The Diet Center Weight Loss Done Right does not offer refunds on any services or products.
- I understand that I have the right not to participate in this program or discontinue for any reason.
- I understand that I have the right to ask questions and to know the purpose and objectives of the program.
- I understand that I will be charged a Late Cancellation Fee of \$25.00 if I fail to give at least 24-hour notice prior to canceling my appointment.
- I understand that I will be charged a No-Show Fee of \$25.00 if I fail to show for my appointment. I understand I must pay this fee at my next appointment to continue with your program and purchase products.

Having read the above, I hereby consent to The Diet Center Weight Loss Done Right weight loss program. Failure to comply with the above could result in termination from the program.

Signed in _____ (city/state), on this _____ day of _____, 20 _____.	
Witness name (printed): _____	
Client name (printed): _____	
_____	_____
<b>Client signature</b>	<b>Witness Signature</b>

## ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I have received the summary page of The Diet Center Weight Loss Done Right's Notice of Privacy Practices (Page 1).

I understand that I have access to the full notice at any time I request it. I understand that the full Notice of Privacy Practices are available on the website (www.TheDietCenter.com), on display at every location, as well I can receive a full copy anytime I request them in writing.

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

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Name—*Please print clearly*

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Signature

Date

### For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) \_\_\_\_\_

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Office staff signature

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Date

