The Diet Center
Weight Loss Done Right!

# Health Profile

Initial Consultation Date/Time:_____

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

## Legend (For Office 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:

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

The Diet Center
*Weight Loss Done Right!*

## PHYSICIANS: Reviewed: ☐

**Who is your primary care physician?:** _____

Please list any other physicians who treat you and their specialty:

Physician name: _____ Specialty: _____

Physician name: _____ Specialty: _____

Physician name: _____ Specialty: _____

Physician name: _____ Specialty: _____

## DIABETES: ☐ N/A Reviewed: ☐

Do you have diabetes: ☐ Yes ☐ No ***If no, please skip to next section***

If yes, which type: ☐ Type 1—Insulin dependent (insulin injections only)—**ALTERNATIVE PROTOCOL ONLY**

☐ Type 2—Insulin dependent (diabetic pills, and/or insulin injections)

Is your blood sugar monitored? ☐ Yes ☐ No If yes, how often?: _____

If so, by whom?: ☐ Myself ☐ Physician ☐ Other _____

Do you tend to be hypoglycemic?: ☐ Yes ☐ No ***If yes, please inquire about our alternative protocol.***

***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.***

## CARDIOVASCULAR FUNCTION: ☐ N/A Reviewed: ☐

Do you or have you had any of the following conditions?:

☐ Arrythmia **(NPA)**
☐ Blood clot **(NPA)**
☐ Coronary artery disease **(NPA)**
☐ Heart attack **(NPC)—*Must be 6 months post***
☐ Heart valve problem **(NPA)**
☐ Heart valve replacement **(NPA)**
☐ Hyperlipidemia (high cholesterol/triglycerides)
☐ Hyperkalemia (high potassium) **(NPA)**
☐ Hypokalemia (low potassium) **(NPA)**
☐ Hypertension (high blood pressure) **(NPA)**
☐ Pulmonary embolism **(NPA)**
☐ Stroke or transient ischemic attack **(NPA)**
☐ Congestive heart failure **(NPA)**
☐ Please select one (if applicable)
☐ History of congestive heart failure
☐ Current congestive heart failure

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

Have you ever had any type of heart surgery? ☐ Yes ☐ No
If yes, what type and when?: _____

The Diet Center
*Weight Loss Done Right!*

## KIDNEY FUNCTION: ☐ N/A Reviewed: ☐

Have you had any of the following conditions?:

☐ Kidney disease **(NPA)**

☐ Kidney transplant **(NPA)**

☐ Kidney stones—***Must drink 80-100oz water daily***

☐ Do you presently or have you ever had gout? ☐ Yes ☐ No If yes, since when?: _____

If yes, what medication has been prescribed?: _____

If you answered yes to any of the above, please give **all** dates of occurrence and current status:

_____

## LIVER FUNCTION: ☐ N/A Reviewed: ☐

Have you ever had any liver conditions?: ☐ Yes ☐ No

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

## COLON FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Constipation
☐ Crohn's disease
☐ Diarrhea
☐ Diverticulitis
☐ Irritable bowel syndrome
☐ Ulcerative colitis

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

## DIGESTIVE FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions:

☐ Acid reflux
☐ Celiac disease
☐ Gastric ulcer **(NPA)--If yes, is your ulcer healed?** ☐ Yes ☐ ***No—If no, cannot do this program***
☐ Gluten intolerance
☐ Heartburn
☐ History of bariatric surgery **(NPA)**
If yes, date and type of surgery and current status: _____

If you answered yes to the above, please give **all** dates of occurrence and current status: _____

_____

The Diet Center
*Weight Loss Done Right!*

## OVARIAN/BREAST FUNCTION: ☐ N/A Reviewed: ☐

Do you currently have any of the following conditions?:

☐ Amenorrhea ☐ Irregular periods

☐ Fibrocystic breasts ☐ Menopause

☐ Heavy periods ☐ Painful periods

☐ Hysterectomy ☐ Uterine fibroma

Date of last menstrual cycle: _____

Are you taking or on any type of contraceptive birth control? ☐ Yes ☐ No
***If yes, IMPORTANT--Changes in estrogen levels may render birth control methods less effective.***

Are you pregnant? ☐ Yes ☐ No ***If yes, cannot do program***

Are you breastfeeding ☐ Yes ☐ No ***If yes, cannot do program***

## ENDOCRINE FUNCTION: ☐ N/A Reviewed: ☐

Do you have thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have para thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have adrenal gland problems?: ☐ Yes ☐ No

If yes, specify: _____

Have you been told you have Metabolic Syndrome?: ☐ Yes ☐ No

## NEUROLOGIC/EMOTIONAL FUNCTION: ☐ N/A Reviewed: ☐

Do you have any of the following conditions??

☐ Alzheimer's disease—***Cannot do this program*** ☐ Depression

☐ Anorexia (history of) ☐ Epilepsy--date of last seizure _____

☐ Anxiety ☐ Panic attacks

☐ Bulimia (history of) ☐ Schizophrenia

☐ Bipolar disorder ☐ Parkinson's **(NPA)**
If yes, taking Lithium? ☐ Yes
**(NPA)— VERY IMPORTANT**--***You must have your lithium levels monitored closely by the physician treating you for this disorder during weight loss. They may need to adjust your medication dosage as you lose weight.***

☐ Other : _____

The Diet Center
*Weight Loss Done Right!*

## INFLAMMATORY CONDITIONS: ☐ N/A Reviewed: ☐

☐ Chronic fatigue syndrome
☐ Fibromyalgia
☐ Lupus
☐ Migraines
☐ Multiple sclerosis
☐ Osteoarthritis
☐ Psoriasis
☐ Rheumatoid arthritis
☐ Other autoimmune or inflammatory condition:

_____

## CANCER: Reviewed: ☐

**Have you ever had cancer?** ☐ No ☐ Yes **(NPA)**

What type and date of diagnosis?: _____

Do you have cancer now? ☐ No ☐ Yes**—Cannot do program**

What type and date of diagnosis?: _____

Is your cancer in remission?: ☐ Yes ☐ No If yes, since when? _____

## GENERAL HEALTH: Reviewed: ☐

**Do you have sleep apnea?:** ☐ Yes ☐ No Since: _____

Do you have any other health conditions not discussed? ☐ Yes ☐ No

If yes, please note: _____

_____

## FOOD ALLERGIES: Reviewed: ☐

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, please specify: _____

The Diet Center
*Weight Loss Done Right!*

## 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: _____

The Diet Center
*Weight Loss Done Right!*

## 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 and/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: _____

The Diet Center
*Weight Loss Done Right!*

## MEDICATIONS & SUPPLMENTS INCLUDING OVER-THE-COUNTER:

**Please lists all prescription medications and supplements you currently take.**
**Refer to the example in line one. If you take no medications, please check box below.**

❑ **Check this box if you take no medications or supplements and initial here: _____**

| Name of medication | Milligrams* per capsule | Number of capsules per day | Number of doses per day | Prescribing physician | Reason for taking this medication |
|---|---|---|---|---|---|
| Medication X | 500mg | 1 | 1 x per day | Dr. John Doe | **Reason/diagnosis** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*Or grams, mEq, or dosage unit your physician prescribes.

**Reviewed** ☐

The Diet Center
*Weight Loss Done Right!*

## 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 "Center") 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 if I have any of the conditions marked NPA on this form, 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 Center 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 Center 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 for best results 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 Center and/or my physician **any and all changes in my health status**, discomfort, symptoms, upcoming surgeries, or any 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.

The Diet Center
*Weight Loss Done Right!*

## COACHING AGREEMENT

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.

## CLIENT RESPONSIBILITIES:

- 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): _____

_____ _____

**Client signature** **Witness Signature**

The Diet Center
*Weight Loss Done Right!*

# 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.
- 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) or any time I request them.
- 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.

_____

Name--*Please print clearly*

_____

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 the Acknowledgment**
- ☐ **Other (Please Specify) _____**

_____

_____

**Office staff signature** **Date**