



## 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.

### ***General***

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Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ P.O. Box: \_\_\_\_\_

Tel. (daytime): \_\_\_\_\_ Tel. (evening): \_\_\_\_\_

Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Profession: \_\_\_\_\_

Wake Time: \_\_\_\_\_ Bedtime: \_\_\_\_\_

**On a scale of 1 to 10, indicate what level of importance you give to the Ideal Protein treatment (10 being the most important) :** \_\_\_\_\_

### ***Marital Status:***

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What is your marital status? \_\_\_\_\_

Do you have children?  Yes  No

Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

### ***Medical Information:***

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#### ***Diabetes:***

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Do you have diabetes?  Yes  No

If so, are you under the care of a physician?  Yes  No

If so, which type?

- Type I – insulin dependent (insulin injections);
- Type II – non-insulin dependent (diabetes pills);
- Insulin required (diabetes pills followed by 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 hypoglycaemic?  Yes  No

**Cardiovascular Disease:**

Have you had a cardiovascular event?  Yes  No

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 hypertension (high blood pressure)?  Yes  No

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 insufficiency?  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: \_\_\_\_\_

**Liver Function:**

Do you have liver problems?  Yes  No

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: \_\_\_\_\_

**Digestive Function:**

Do you have:  Irritable colon  Colitis  Diarrhea  
 Diverticulitis  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 Function:**

Do you have:  Acid reflux  Gastric ulcer  Heartburn

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list: \_\_\_\_\_

**Ovarian Function:**

Check off the situations that apply to you:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Menopause       | <input type="checkbox"/> Mammography             |
| <input type="checkbox"/> Painful periods   | <input type="checkbox"/> Hysterectomy    | <input type="checkbox"/> Heavy periods           |
| <input type="checkbox"/> Amenorrhea        | <input type="checkbox"/> Uterine fibroma | <input type="checkbox"/> Cancer (uterus, breast) |

If so, are you under the care of a physician?  Yes  No

Are you taking any medication?  Yes  No

If so, please list: \_\_\_\_\_

Please indicate the next date of your menstrual cycle : \_\_\_\_\_

**Thyroid Function:**

Do you have thyroid problems?  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: \_\_\_\_\_

**Emotional Evaluation:**

Check off the situations that apply to you:

- |                                     |                                       |  |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Migraines  | <input type="checkbox"/> Panic attack | <input type="checkbox"/> Spasmophilia        |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bulimia      | <input type="checkbox"/> History of anorexia |

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 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 pregnant?  Yes  No

Are you breastfeeding?  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 medication?  Yes  No

If so, please list: \_\_\_\_\_

Are you taking other medication?  Yes  No

<b>Drug Name</b>	<b>Since</b>	<b>Reason</b>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**Allergies:** \_\_\_\_\_

Do you have food allergies?  Yes  No

If so, please list: \_\_\_\_\_

**Eating Habits:** \_\_\_\_\_

**Breakfast** \_\_\_\_\_

Do you have breakfast every morning?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

Do you have a snack before lunch?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

**Lunch**

Do you have lunch every day?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

Do you have a snack before dinner?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

**Dinner**

Do you have dinner every day ?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

**Evening**

Do you eat in the evening?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

Do you eat at night?  Yes  Sometimes  Never

Example Day 1 : \_\_\_\_\_

Example Day 2 : \_\_\_\_\_

**Other**

Do you prefer:  Sweet foods  Salty foods  Fatty foods

How many glasses of water do you drink per day? \_\_\_\_\_ glasses

How many cups of coffee do you drink per day? \_\_\_\_\_ cups

Do you drink alcohol?  Sometimes  Weekends  Regularly

Do you smoke?  Yes  No

Are you a vegetarian?  Yes  No

Have you been on a diet before?  Yes  No

If so, please specify: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Date diet ended: \_\_\_\_\_

You must take vitamins and minerals while you are on this diet. 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 protein diet.