Health Profile

Date:_____

Dietary consultation involves a health profile. The purpose of the health profile 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.

First name:_____ **Last name**: _____
Address:_____
City:_____ State:_____ Zip code: _____
Phone: _____
Email: _____
Date of birth: _____ Age: _____
Profession: _____
Referral: _____

Current weight (lb): _____ Weight 1 year ago (lb):_____
Minimum adult weight (lb): _____ At age: _____
Maximum adult weight (lb): _____ Height: _____

Do you exercise? _____Yes _____ No If yes, what kind?
_____
How often? _____ Daily _____ Weekly _____Other

Have you been on a diet before? _____Yes _____No
If yes, please specify which diet(s) and why you think it didn't work for you (i.e. too rigid, too much cooking
involved, etc.)
_____
_____
_____
_____
_____

On a scale of 1 to 10, indicate what level of importance you give to losing weight with Lean Life's professionally supervised weight loss method: (circle one)

Least important **1 2 3 4 5 6 7 8 9 10** Very important

What is your marital status? ___Married ___Single ___Widow ___Divorce ___Other
How many children do you have? _____ How old are they?_____
Who does most of the cooking at home?_____
On average, how many hours do you sleep per night? _____

Who is your primary care physician (family doctor)?
_____
Please list any physicians you see and their specialty (refer to medical information for list of disorders):
Dr. Specialty: Patient since:
(MM/YY)_____
Dr. Specialty: Patient since:
(MM/YY)_____
Dr. Specialty: Patient since:
(MM/YY)_____
Dr. Specialty: Patient since:
(MM/YY)_____
Dr. Specialty: Patient since:
(MM/YY)_____
Dr. Specialty: Patient since:
(MM/YY)_____

Do you have diabetes? _____Yes _____No If no, please skip to next section.

If yes, 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, how often? _____

If so, by whom? _____Myself _____Physician

Other – please specify:
_____

Do you tend to be hypoglycemic? _____Yes _____No
NOTE: If you are currently on a Sodium-Glucose Co-Transporter inhibitor (SGLT-2), do not start the weight loss method.

Have you had any of the following conditions?

___Arrhythmia (NPA - if not on Rx medication)
___Blood Clot (NPA)
___Coronary Artery Disease (NPA)
___Heart attack (NPC)
___Heart Valve Problem (NPA)
___Heart Valve Replacement (porcine/mechanical) (NPA)
___Congestive Heart Failure (NPC)
___Hyperlipidemia Please select one (if applicable):
_____High cholesterol _____triglycerides)
___History of Congestive Heart Failure
___Current Congestive Heart Failure (NPC)
___Hyperkalemia (High potassium) (NPA)
___Hypokalemia (Low potassium) (NPA)
___Hypertension (High blood pressure)
___Pulmonary Embolism (NPA)
___Stroke or Transient Ischemic Attack

Have you ever had **any** type of heart surgery? _____Yes _____No
If so, which type?
_____
_____
Other conditions:
_____
_____

If you have answered yes to any of the above conditions, please give **all** dates of occurrence:
_____
_____

Have you had any of the following conditions:
_____Kidney Disease (NPA)
_____Kidney Transplant (NPA)
_____Kidney Stones
Do you presently have gout? _____Yes _____No Since when: _____
If yes, what medication has been prescribed?
_____
If no, have you ever had gout? _____Yes _____No
If yes, when?
_____
If yes to any of these events, please give dates of events. For multiple events please specify:
_____

Have you ever had any liver conditions? _____Yes _____No If yes, Date: _____
If yes, please list:
_____
_____
Have you ever had a gallstone incident? _____Yes _____No

Do you have any of the following conditions:

_____Constipation
_____Crohn's Disease
_____Diarrhea
_____Diverticulitis
_____Irritable Bowel Syndrome
_____Ulcerative Colitis

If yes to any of these conditions, please give dates of events. For multiple events please specify:

_____
_____
_____
_____

Do you have any of the following conditions:

_____Acid Reflux
_____Celiac Disease
_____Gastric Ulcer (NPA)
_____Gluten intolerance
_____Heartburn
_____History of Bariatric Surgery (NPA)

If so, what type of bariatric surgery?

_____
_____
_____

Do you currently have any of the following conditions:

_____Amenorrhea
_____Fibrocystic Breasts
_____Heavy periods
_____Hysterectomy
_____Irregular periods
_____Menopause
_____Painful periods
_____Uterine Fibroma

Date of last menstrual cycle: _____
Are you taking oral contraceptive pills? _____Yes _____No
Are you pregnant? _____Yes _____No
Are you breastfeeding? _____Yes _____No

Do you have thyroid problems? _____Yes _____No
If so, please specify:

_____

Do you have parathyroid problems? _____Yes _____No
If so, please specify:

_____

Do you have adrenal gland problems? _____Yes _____No
If so, please specify:

_____

Have you been told you have Metabolic Syndrome? ____Yes _____No

Do you have any of the following conditions:

_____Alzheimer's disease
_____Anorexia (History of)
_____Anxiety
_____Bipolar disorder
_____Bulimia (History of)
_____Depression
_____Epilepsy (NPA)
_____Panic attacks
_____Parkinson's disease
_____Schizophrenia

Other issues:
_____
_____
_____

Do you have any of the following conditions:

_____Chronic Fatigue Syndrome	_____Multiple Sclerosis
_____Fibromyalgia	_____Osteoarthritis
_____Lupus	_____Psoriasis
_____Migraines	_____Rheumatoid

_____Other autoimmune or inflammatory condition

Do you have cancer? (NPC) _____Yes _____No
If so, what type and where is it located?
_____
Have you ever had cancer? (NPC) _____Yes _____No
If so, what type and where is it located?
_____
Is your cancer in remission? (NPC) _____Yes _____No
If so, how long have you been in remission? (mm/yy)
_____

Do you have any other health problems? _____Yes _____No
If so, please specify:
_____
_____
_____

Do you have any food allergies or sensitivities? _____Yes _____No
If so, please specify:
_____
_____
_____

(Please provide honest answers so that we can help you)

BREAKFAST

Do you have breakfast every morning? ___Yes____Sometimes ___No ___Never
Approximate time: _____
Examples:
_____

Do you have a snack before lunch? _____Yes _____Sometimes _____No _____Never
Approximate time: _____
Examples:
_____

LUNCH

Do you have lunch every day? _____Yes _____Sometimes _____No _____Never
Approximate time: _____
Examples:
_____

Do you have a snack before dinner? _____Yes _____Sometimes _____No _____Never
Approximate time: _____
Examples:
_____

DINNER

Do you have dinner every day? _____Yes _____Sometimes _____No _____Never
Approximate time: _____
Examples:
_____

Do you have a snack at night? _____Yes _____Sometimes _____No _____Never
Approximate time: _____
Examples:
_____

OTHER

Are you a vegan? _____Yes _____No
Strict vegans do not qualify due to too many dietary restrictions.
Are you a vegetarian? _____Yes _____No

Do you smoke? _____Yes _____No If so, how many per day?_____
For how many years? _____

Do you drink alcohol? _____Yes _____No
If so, what and how often?_____

How many glasses of water do you drink per day? _____glasses per day

How many cups of coffee do you drink per day? _____cups per day

Please list all prescription medications and supplements you are currently taking.

Confirmation of Full Health Status Disclosure by the Client and Agreement to Arbitrate Disputes

I confirm that the information that I have provided and that is recorded by me on this Lean Life 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 highlighted in purple / identified as NPC or NPA on this form.** Furthermore, I understand that I should not be undertaking or otherwise following the Lean Life Weight Loss Method 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 Lean Life Weight Loss Method, ii) remain under the supervision of said medical doctor while I am on the Lean Life Weight Loss Method, and iii) provide documentation confirming the foregoing.

I understand that if i) I have any of the aforementioned conditions or if I am currently taking any of the aforementioned medication, ii) have not disclosed same to the clinic and iii) nevertheless chose to go on the Lean Life Weight Loss Method without specific supervision, such decision will be completely voluntary, and I release and discharge the clinic as well as employees and/or representativesfrom 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.

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

Without limitation to the foregoing, I confirm that I have been advised that because the Lean Life Weight Loss Method limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am on the Lean Life Weight Loss Method.

I undertake to disclose immediately to the clinic any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am on the Lean Life Weight Loss Method.

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 province of residence, and I waive any rights to pursue any claims or causes of action in any court of law.

Signed in _____ (city/state), on this _____ day of _____, 20_____.

Name of witness: _____

Name of client (print): _____

Signature: _____