Health Profile to be Completed by New Patients and Clients

Today's Date:	Nurse:
Dietary consultation involves a health profile, the purpose of which is not to establish a diagnosis, but rather to determine a patient or client's health status in order to guide his or her weight loss plan. A patient or client may be advised to seek medical advice based on his or her health profile. Please click into the grey boxes to begin typing and to preserve formatting.	
Legend (For HIDRATION Staff use only)	
NPA - Needs Prescriber Approval	NPC -Needs Prescriber Care (and approval)
NPA/M -Needs Prescriber Approval with Medication Monitoring	

1. Personal Information		
First Name:	Last Name:	
Address:		Apt/Unit:
City:	State:	ZIP:
Home Phone:	Mobile Phone:	
Email:		
Date of Birth (mm/dd/yyyy):		Age
Profession:		Employer:
How did you hear about us?		
Who referred you?		

2. General information and Lifestyle Choices	
Current Weight (lbs):	Weight 1 year ago (lbs):
Lowest Adult Weight:	Age:
Highest Adult Weight:	Age:

Height: _____ Ft _____ in	
Do you exercise? YES ◯ NO ◯	If Yes, what kind?
	How Often
If no, why not?	
Have you been on a diet before? YES ◯ NO ◯	
If yes, please specify which diets, and why you think it did not work for you for example, too rigid, too much cooking, etc.)	
_____	
_____	
_____	
Are you currently a vegan?	No ☐
	Yes (exclusion) _____
Are you currently a vegetarian?	Yes ◯ No ◯
What is your marital status? Married ☐ Single ☐ Divorced ☐	
How many children do you have? _____ Ages? _____	
Who does most of the cooking at home?	
On average, how many hours per night do you sleep?	

3. Primary Care Physician, Surgeries, and Specialists Information

Who is your primary care physician (family doctor)?	Name:
	Telephone Number:
	Fax Number:
	Email:
When was your last blood work performed?	Date:
Have you had surgery in the last 6 months?	Yes ◯ No ◯
If so, what type? (Dates)	

3.1 Primary Care Physician, Surgeries, and Specialist Information	
Please list any physicians you see and their specialty:	
Dr. _____	Specialty: _____
Patient Since: _____	Last Visit: _____
Dr. _____	Specialty: _____
Patient Since: _____	Last Visit: _____
Dr. _____	Specialty: _____
Patient Since: _____	Last Visit: _____

4. Diabetes ☐ N/A - Please check if this does not apply

If so, which type?

- ○ Type I - Insulin-dependent Iinsulin injections only) (NPC)
- ○ Type II - Non-insulin-utilizing (diabetic pills) (NPA/M)
- ○ Type II - Insulin-untilizing (diabetic pills and insulin) (NPA/M)

Is your blood sugar level monitored? Yes ○ No ○

If so, how? _____

What is the frequency ? _____

If so, by whom? ☐ Myself ☐ Physician

Do you tend to be hypoglycemic? Yes ○ No ○

5. Cardiovascular Function ☐ N/A Please check this box if this category does not apply

Do you have/have you had any cardiac (heart) problems (i.e. arrythmia, heart valve replacement, hypertension, heart failure?)

Yes (NPC) ○ No ○

6. Metabolic Conditions ☐ N/A Please check this box if this category does not apply

Have you had or currently have any of the following conditions?

Hyperlipidemia (high cholesterol) Gout (NPC) ☐ When: _____

Medication prescribed for your gout? ☐

If "yes" to any of these conditions, please provide the dates and specifics of the events, if applicable:

7. Kidney Function ☐ N/A Please check this box if this category does not apply

Have you had or currently have any of the following conditions?

Severe Kidney Disease (exclusion) ☐ Kidney Disease **(NPA)** ☐

Kidney Transplant **(NPA)** ☐ Kidney Stones? ☐ Type?

If "yes" to any of these conditions, please provide the dates and specifics of the events, if appplicable_____

_____

8. Liver Function ☐ N/A Please check this box if this category does not apply

Severe Liver Disease (exclusion) ☐ Chronic Liver Disease (NPC) ☐

Hepatitis (NPC) ☐ Cirrhosis (NPA} ☐

Fatty Liver Disease (NPC) ☐ Gallstone ☐

Please provide dates, if applicable: _____

If other liver conditions, please list: _____

9. Colon Function ☐ N/A Please check this box if this category does not apply

Do you have any bowel issues (IBS, constipation, diarrhea, etc.)?

Yes (please list) ○ No ○

10. Digestive Function ☐ N/A Please check this box if this category does not apply

Acid Reflux and/or Heartburn ☐ Celiac Disease ☐

Bariatric surgery (or history of) **(NPA)** ☐ Gluten Intolerance ☐

If surgery, what type? _____

11. Endocrine Function ☐ N/A Please check this box if this category does not apply

Have you had or currently have any of the following conditions?

☐ Thyroid issues (NPA/M) ☐ Adrenal disease

☐ Parathyroid issues ☐ Other?

If so, please specify: _____

12. Ovarian and Breast Function

☐ N/A Please check this box if this category does not apply

Do you currently have any of the following conditions?

☐ Irregular periods / Amenorrhea
☐ Menopause
☐ Pregnant **(NPC -OB/GYN)**
☐ Hysterectomy
☐ Polycystic Ovarian Syndrome (PCOS)
☐ Breastfeeding **(NPC Pediatrician)**

Date of last menstrual cycle: _____

Are you using any contraception? Yes ◯ No ◯ Type: _____

13. Neurological Function

☐ N/A Please check this box if this category does not apply

Do you have any of the following conditions?

Alzheimer's disease or dementia **(NPA)** ☐
Parkinson's disease **(NPA)** ☐
Other: _____
Epilepsy **(NPA)** ☐
Date of last seizure: _____

14. Emotional Function

☐ N/A Please check this box if this category does not apply

Do you have any of the following conditions?

Anorexia (or history of) **(NPC)** ☐
Bulimia (or history of) **(NPC)** ☐
Anxiety **(NPC)** ☐
Bipolar disorder **(NPC)** ☐
(Note medications, i.e. lithium) _____
Major Depression **(NPA)** ☐
Schizophrenia **(NPC)** ☐
Other:_____
Other: _____

15. Inflammatory Conditions

☐ N/A Please check this box if this category does not apply

Do you have any of the following conditions?

☐ Fibromyalgia
☐ Migraines
☐ Lupus
☐ Multiple Sclerosis
☐ Psoriasis
☐ Rheumatoid

If any, please specify other autoimmune or inflammatory conditions:

_____

16. Cancer

☐ N/A Please check this box if this category does not apply

Do you currently have cancer? (**NPC & requires written consent from Oncologist**)

Yes ◯ No ◯

If so, what type? Local or metastatic? _____

Is your cancer in remission? ◯ Yes **(NPA)** No ◯

17. Allergies

☐ N/A Please check this box if this category does not apply

Do you have any of the following conditions?

Food Allergies If so, specify _____

Food Intolerances If so, specify _____

Gluten Sensitivity If so, specify _____

Other? _____

18. Other Health Conditions

☐ N/A Please check this box if this category does not apply

Do you have any other health conditions? Yes ◯ No ◯

If so, please specify: _____

_____

19. Drink Consumption

Do you drink alcohol? Yes ◯ No ◯

I understand that the consumption of any type of alcohol has adverse effects on my health, reduces the effectiveness of my medication, and will hinder my body's ability to obtain my optimal weight loss goals.

☐ Initials

How many glasses of water do you drink per day?	☐	Glasses
How many cups of coffee (or caffeinated tea) do you drink per day?	☐	Cups
How much cream or milk do you use?	☐	Tbs
How much sugar or sweeteners do you use?	☐	Tbs
How many glasses of juice do you drink per day?	☐	Glasses
How many sport or energy drinks do you drink per day?	☐	Cans
How many soft drinks (soda/pop) do you drink per day?	☐	Cans

20. Eating Habits - Please provide your typical dietary habits

BREAKFAST

Do you eat breakfast every morning? ◯ Yes ◯ Sometimes ◯ No

Approx. time? _____

Examples of typical foods?

SNACK BEFORE LUNCH

Do you have a snack before lunch? ◯ Yes ◯ Sometimes ◯ No

Approx. Time? _____

Examples of typical foods? _____

LUNCH

Do you eat lunch every day? ◯ Yes ◯ Sometimes ◯ No

Approx. Time? _____

Examples of typical foods? _____

SNACK BEFORE DINNER

Do you have a snack before dinner? ◯ Yes ◯ Sometimes ◯ No

Approx. Time? _____

Examples of typical foods? _____

DINNER

Do you eat dinner every day? ◯ Yes ◯ Sometimes ◯ No

Approx. Time? _____

Examples of typical foods? _____

SNACK AT NIGHT

Do you have a snack at night? ◯ Yes ◯ Sometimes ◯ No

Approx. Time? _____

Examples of typical foods? _____

21. Medications & Supplements

Please list all prescription medications, supplements and vitamins.
Please refer to the example in the first line.

Name of medication/ supplement	Milligrams per capsule/Tablet	Number of capsules/tablets per day	Number of doses per day	Prescribing Dr.	Reason for taking
Medication "X"	500mg	1	3x day	Dr. John Doe	Thyroid

Confirmation of full health status disclosure by the client and agreement to arbitrate disputes

I confirm that the information that I have provided to my Hidration LLC service provider (the "**Clinic**") and that is recorded by me on this Hidration 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 conditions identified as NPA and/or NPC on this form. Furthermore, I understand that I should not be undertaking or otherwise following the Hidration Semaglutide 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 follow the Hidration Semaglutide Protocol, ii) remain under the supervision of said medical doctor while I am on the Hidration Semaglutide Protocol, 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 follow the Hidration 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 Hidration, LLC., 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 Hidration Protocol.

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

Without limitation to the foregoing, I confirm that I have been advised that because the Hidration Protocol limits the ingestion of certain foods, it is important that I consume the recommended vitamins and minerals while I am following the Protocol.

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 following the Hidration Protocol.

Signed in:_____(City/State), on this _____ day of _____ 2023

Client Name (Print) _____

Hidration Witness Name (Print) _____

_____ _____

Client Signature **Hidration Witness Signature**

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.

CLEAR ALL FIELDS