evolve180

HEALTH PROFILE

OVERALL (Please use print characters)

Name:

Address:

City, State, Zip:

Phone: Email:

Age: **Height:** **Date of Birth:**

How did you hear about Evolve180?

Job/Occupation: Marital Status:

Do you have children? ❑ Yes ❑ No Ages?

PURPOSE OF VISIT

What do you hope we can accomplish together?

What have been your biggest challenges preventing you from reaching this on your own?

Would you like to learn about boosting your progress with Red Light therapy? ❑ Yes ❑ No

Have you been on a weight loss program before? ❑ Yes ❑ No

If yes, which program(s) and what worked/did not work for you?

EXERCISE AND HABITS

Do you currently exercise? ❑ **Yes** ❑ No

If so, what kind? _____

How often? _____

On average, how many hours of sleep do you get per night? _____

On a scale of 1 to 10, indicate what level of importance you place on losing weight: (circle one)

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

On a scale of 1 to 10, indicate your daily stress level: (circle one)

No stress 1 2 3 4 5 6 7 8 9 10 Very stressed

Do you follow any of the following diets? ❑ None ❑ **Vegan** ❑ Vegetarian Other _____

Do you drink alcohol? ❑ Yes ❑ No If so, what and how often? _____

Do you smoke? ❑ Yes ❑ No How much? _____

How many glasses of **water** do you drink per day? _____

How many cups of **coffee** do you drink per day? _____

MEDICAL HISTORY

Who is your primary/main Physician? _____

Would you like us to communicate with them during your weight loss journey? ❑ **Yes** ❑ No

If yes, provide contact information: _____

I HEREBY *authorize Evolve180 and the above named Physician to share information relevant to my participation in Evolve180's weight loss protocol.*

Printed Name: Signature: Date:

HEART AND VASCULAR CONDITIONS Please check all that apply

❑ None

❑ **Hypertension** (high blood pressure)

❑ Hyperlipidemia (high cholesterol)

❑ **Heart Valve Problem**

❑ **Heart Valve Replacement**

❑ **Arrhythmia/A-Fib**

❑ **Heart Attack (prior to last 3 years)**

❑ **Heart Attack (within last 3 years)**

❑ **Coronary Artery Disease**

❑ **Hypokalemia (low potassium)**

❑ **Hyperkalemia (high potassium)**

❑ **Blood Clot** - On medication? ❑ Yes ❑ No

❑ **Stroke or Transient Ischemic Attack**

❑ **Pulmonary Embolism**

❑ **Congestive Heart Failure**

Have you ever had any type of heart surgery? ❑ **Yes** ❑ No

Please describe including date, and any ongoing symptoms:

If you checked any bold or highlighted items above, what current symptoms / treatment are you receiving?

Medications (blood pressure, cholesterol, heart, or vascular conditions) *attach separate sheet if needed.

Condition	Medication	Dose per day

LIVER FUNCTION Please check all that apply

Have you ever had any diagnosed liver conditions? ❑ **Yes** ❑ No

If yes, please list:

CANCER Please check all that apply

Do you have cancer? ❑ **Yes** ❑ No

If yes, please list what type and when:

Do you have a history of cancer? ❑ **Yes** ❑ No

If yes, please list what type and when:

DIABETES Are you diabetic or pre-diabetic? (select which applies to you)

❑ No, I am not diabetic or pre-diabetic

❑ No, I am not diabetic, but I have a family history of type 2 diabetes

❑ I have been diagnosed as pre-diabetic or having "metabolic syndrome"

❑ **Type 2 – Non-Insulin Dependent** → Indicate Medications*: _____

❑ **Type 2 – Insulin Dependent** → Indicate Medications*: _____

Insulin-dependent type 2 diabetes need to follow special instructions on the weight loss protocol. Your coach will explain.

❑ **Type 1 Diabetes** → Indicate Medications*: _____

Who measures your blood sugar levels? _____ How frequently? _____

MEDICATION ALERT FOR TYPE 2 DIABETES

*If you are currently on a **Sodium-Glucose Co-Transporter inhibitor** (SGLT-2), DO NOT start the weight loss method. Examples include Forxiga, Invokana, Jardiance, Ebymect, Edistride, meds ending with "-agliflozin".*

***I CERTIFY** that I am not taking SGLT-2 inhibitors and that if at any time my doctor prescribes them, I will discontinue the standard baseline protocol with Evolve180 and continue only on an alternative (non-ketogenic) protocol for my own safety while I'm a client of Evolve180.*

Client Initials:

KIDNEY FUNCTION Please check all that apply

❑ None

❑ **Gout;** If so, do you currently have symptoms? ❑ Yes ❑ No

Medicated? ❑ Yes ❑ No Which medications? _____

Date of most recent attack: _____

❑ **Kidney stones;** If so, do you currently have symptoms? ❑ Yes ❑ No

Medicated? ❑ Yes ❑ No Which medications? _____

Date of most recent attack: _____

❑ **Kidney Disease**

❑ **Kidney Transplant**

COLON AND DIGESTIVE FUNCTION

Please check all that apply

❑ None

❑ **Constipation**

❑ Diarrhea

❑ Heartburn / Acid Reflux/GERD

❑ **Crohn's Disease**

❑ History of **Bariatric surgery** → If yes, what type and when? _____

❑ **Irritable Bowel Syndrome** → When was the last flare? _____

❑ **Gastric Ulcer** → If yes, are symptoms currently present? Please explain:

_____

_____

❑ **Celiac Disease**

❑ **Diverticulitis**

❑ **Ulcerative Colitis**

❑ Gluten Intolerance → Diagnosed? ❑ Yes ❑ No

ENDOCRINE FUNCTION

Do you have thyroid problems? ❑ Yes ❑ No

If yes, please specify: _____

Do you have parathyroid problems? ❑ Yes ❑ No

If yes, please specify: _____

Do you have adrenal gland problems? ❑ Yes ❑ No

If yes, please specify: _____

Medications (Endocrine Function) *attach separate sheet if needed.

Condition	Medication	Dose per day

INFLAMMATORY AND/OR AUTOIMMUNE CONDITIONS

Please check all that apply

❑ None

❑ Migraines

❑ Osteoarthritis

❑ Lupus

❑ Fibromyalgia ❑ Multiple Sclerosis

❑ Psoriasis ❑ Other: _____

❑ Rheumatoid arthritis

Medications (Inflammatory / Autoimmune Conditions) *attach separate sheet if needed.

Condition	Medication	Dose per day

OVARIAN / BREAST FUNCTION

Please check all that apply

❑ None ❑ Uterine Fibroma

❑ Painful periods ❑ Hysterectomy

❑ Irregular periods ❑ Menopause

❑ Amenorrhea (no period) ❑ Fibrocystic breasts

❑ **PCOS (Polycystic Ovarian Syndrome)** ❑ Heavy periods

❑ **Taking oral contraceptive pills** *(if yes, use back-up method)*

❑ **Pregnant or breastfeeding** *(if yes, not eligible to participate in weight loss protocol)*

EMOTIONAL/PSYCHOLOGICAL/ NEUROLOGICAL FUNCTION

Please check all that apply

❑ None

❑ Depression → Diagnosed? ❑ Yes ❑ No; Medicated? * ❑ Yes ❑ No

❑ Anxiety → Diagnosed? ❑ Yes ❑ No; Medicated? * ❑ Yes ❑ No

❑ Panic attacks

❑ **Bipolar disorder?** → Diagnosed? ❑ Yes ❑ No; Medicated? * ❑ Yes ❑ No

❑ Schizophrenia

❑ **Parkinson's disease** ❑ **Alzheimer's Disease** ❑ Epilepsy

❑ Other, please list: _____

* *Please list medications below*

Medications (Emotional/Psychological/Neurological) *attach separate sheet if needed.		
Condition	**Medication**	**Dose per day**

EATING CHALLENGES / DISORDERS

Please check all that apply

- ❑ Compulsive (binge) eating
- ❑ Sugar / carb "addiction" or cravings
- ❑ Current or history of bulimia
- ❑ Current or history of anorexia
- ❑ Alcoholism
- ❑ Cyclic overeating / restrictive eating
- ❑ "Emotional" eating
- ❑ History with 12-step programs for eating
- ❑ Hard to put aside alcohol
- ❑ Eat or drink to sooth or relax

ALLERGIES

Do you have any food sensitivities/ intolerances? ❑ Yes ❑ No

If so, please list: _____

Symptoms when you eat them? _____

How often do you eat them anyway? _____

Do you have any food **"allergies"**? ❑ Yes ❑ No; Diagnosed? ❑ Yes ❑ No

If so, please list: _____

Do these allergies put you into Anaphylactic shock? ❑ Yes ❑ No

Do you carry an Epi-Pen? ❑ Yes ❑ No

OTHER

Do you have any other health concerns? ❑ Yes ❑ No

If so, please specify: _____

Confirmation of Full Health Status Disclosure by Client, and agreement to Arbitrate Disputes

I knowingly and voluntarily make the following agreement with Ideal Northwest, LLC (d/b/a Evolve180 Weight Loss), henceforth to be referred to as "Evolve180".

I confirm that the information that I have provided and that is recorded by me on this Evolve180 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 which are shaded on this form. Furthermore, if I reported having any of the conditions or taking any of the medications specifically printed in bold type on this form, I understand that i) I may need to obtain permission from my physician BEFORE beginning the Evolve180 Program, and/or ii) I may be required to follow specific instructions while on the Program, and iii) I agree to any and all of the requirements as instructed by Evolve180. In the event I am instructed to obtain physician permission before beginning, I agree to i) specifically consult with my medical doctor/ physician about my suitability to go on the Evolve180 Program, ii) remain under the supervision of said physician while I am on the Evolve180 Program, 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 medications, ii) I have not disclosed same to Evolve180 and iii) I nevertheless chose to go on the Evolve180 Program without specific supervision, such decision will be completely voluntary and I release and discharge Evolve180, Ideal Northwest, LLC, its parent companies, subsidiaries and affiliates and 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.

I confirm that the Evolve180 Weight Loss Program has been explained to me, that I have had the opportunity to ask questions relating to the Evolve180 Program, that I have been provided with the answers to such questions and that I understand the importance of strictly following the Evolve180 Program as explained to me verbally and in the materials provide to me, both before and during the period I will be following the Evolve180 Program.

Without limitation to the foregoing, I confirm that I have been advised that because the Evolve180 Program limits the ingestion of certain foods, it is important that I consume the recommended food, supplements, vitamins and minerals while I am on the Evolve180 Program, and follow instructions for limiting heavy workouts and activity.

I undertake to disclose immediately to my Evolve180 Studio and/or Team any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am on the Evolve180 Program.

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.

Signed in (City/State) _____ On (date) _____

Name of Client (print) _____

Signature of Client (sign) _____

Name of Evolve180 Representative (print): _____

Signature of Evolve180 Representative (sign): _____