The Gerber Diet
LIVEWELL

Health Profile

Initial Consultation Date/Time:_____

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

Legend (For clinic use)

NPA – Needs Physician Approval NPC – Needs Physician Care

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? _____

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--**	

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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 (NPC)
- ☐ 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 <u>all</u> dates of occurrence and current status:

_____

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

_____

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 diet***
☐ **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: _____

_____

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 diet***

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

ENDOCRINE FUNCTION: ☐ N/A Reviewed: ☐

Do you have thyroid problems?: ☐ Yes ☐ No

If yes, specify: _____

Do you have parathyroid 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 diet*

☐ Anorexia (history of)

☐ Anxiety

☐ Bipolar disorder
If yes, taking Lithium? ☐ Yes (NPA)

☐ Bulimia (history of)

☐ Depression

☐ Epilepsy--date of last seizure _____

☐ Panic attacks

☐ Parkinson's (NPA)

☐ Schizophrenia

☐ Other : _____

INFLAMMATORY CONDITIONS: ☐ N/A Reviewed: ☐

☐ Chronic fatigue syndrome ☐ Multiple sclerosis

☐ Fibromyalgia ☐ Osteoarthritis

☐ Lupus ☐ Psoriasis

☐ Migraines ☐ Rheumatoid arthritis

☐ Other autoimmune or inflammatory condition:

_____

CANCER: Reviewed: ☐

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

What type and date of diagnosis?:

_____

Do you have cancer now? ☐ Yes ☐ No

What type and date of diagnosis?:

_____

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

_____

GENERAL HEALTH: Reviewed: ☐

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

If yes, please note: _____

_____

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

_____

FOOD ALLERGIES: Reviewed: ☐

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

If yes, please specify:

_____

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:

_____

OTHER: **Reviewed: ☐**

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

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

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 ☐

CONFIRMATION OF FULL HEALTH STATUS DISCLOSURE BY THE CLIENT AND AGREEMENT TO ARBITRATE DISPUTES

I confirm that the information that I have provided to LiveWell ADK, The Gerber Diet (the "Clinic") 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 I do not have any of the conditions and that I am not taking any of the medications specifically **in bold**/ identified as NPC or NPA on this form. Furthermore, 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 Gerber Diet protocol, ii) remain under the supervision of said medical doctor while I am on The Gerber Diet 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 Clinic and iii) nevertheless chose to follow on The Gerber Diet 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 The Gerber Diet, 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 Gerber Diet protocol.

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

Without limitation to the foregoing, I confirm that I have been advised that because The Gerber Diet protocol limits the ingestion of certain foods, it is mandatory that I consume the required vitamins and minerals while I am on The Gerber Diet protocol.

I undertake to disclose immediately to the Clinic and/or my physician any and all changes in my health status, discomfort, symptoms or other health concerns that I may experience while I am following The Gerber Diet 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.

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

Witness name (printed): _____

Client name (printed): _____

_____ _____

Client signature **Witness Signature**

CONSENT AND AGREEMENT TO PARTICIPATE

Our weight loss program is much more than dietary restrictions and lifestyle changes; it is a commitment to yourself and The Gerber Diet. Due to our educational and knowledge-based approach, we insist that you make a commitment to 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 Gerber Diet participants.

We can only effectively coach you to results if you:

- Follow the program ***EXACTLY*** as written making no customized modifications.
- Consume only The Geber Diet 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 journey!
- To maintain your weight loss, ***it is strongly recommended to complete all phases***.

CONSENT TO PARTICIPATE

- I agree to participate in The Gerber Diet'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 Gerber Diet does not offer refunds on any services or purchases. _____
- 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, as of August 1st, 2020, 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 and initialing the highlighted areas, I hereby consent to The Gerber Diet's weight loss program. Failure to comply with the above could result in termination from the program.

_____ _____

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

Photo Consent

BY: _____ (Name)
_____ (Address)
(Hereinafter referred to as the "**Dieter**")
IN FAVOUR OF: **LiveWell ADK** (the "**Clinic**") and
The Gerber Diet (the "Diet")

The Dieter hereby acknowledges and agrees that it has followed the Gerber Diet Weight Loss Method and protocol and used "Gerber Diet" products in connection therewith under the supervision of LiveWellADK. The Dieter hereby irrevocably authorizes the Clinic and Diet to use the Dieter's photos, images, testimonials and/or story in connection with the promotion and sale of The Gerber Diet weight loss and wellness method and protocol as well as "the Gerber Diet" products. This authorization is granted in perpetuity and does not entitle the Dieter to any form of remuneration or compensation.

Signed in Queensbury, NY on this _____ day of _____, 20_____.

The Dieter:_____ (name of the dieter)

Signature: _____

I want to **INSPIRE PEOPLE**.
I want someone to look at me and say,
"Because of you, **I didn't give up.**"

Your pictures and testimonials inspire others, thank you for helping us help them!

Weight Loss Stats

Start weight: _____ Current Weight: _____
Start BMI: _____ Current BMI: _____
Start Body Fat %: _____ Current Body Fat %: _____

Total Inches Lost: _____