



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
- Painful periods
- Irregular periods
- Amenorrhea (no period)
- PCOS (Polycystic Ovarian Syndrome)**
- Using hormonal birth control method (i.e. birth control pills)?** *(if yes, use back-up method)*
- Pregnant or breastfeeding** *(if yes, not eligible to participate in weight loss protocol)*
- Uterine Fibroma
- Hysterectomy
- Menopause
- Fibrocystic breasts
- Heavy periods

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): _____