FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program, personally designed for you.

Today's Date: ____________ Referred by: ____________

Name: ____________ ☐ Male ☐ Female Birthdate: ____________ Age: ______

Mailing Address: ____________

City: ____________ State: ____________ Zip: ______ Occupation: ____________

Height: ______ Weight: ______ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Daytime Phone: ____________ Evening Phone: ____________ No. of children: ______

DO NOT take any supplements for 2 meals before evaluation.

1 Complaints

Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

2 Other Information

Please tell us any additional information or concerns about your health:

3 Medications

Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medications, etc.):

4 Smoking

Do you currently smoke? ☐ No ☐ Yes If yes, how much? ____________

How long have you smoked? ____________

5 Surgeries

What surgeries, operations, traumas, car accidents, etc. have you had?

a.) Have you ever had full-body anesthesia (i.e. *to remove tonsils, wisdom teeth, etc.*)? ☐ No ☐ Yes

b.) Do you have breast implants? Other surgical implants or prostheses? ☐ No ☐ Yes

c.) Have you had elective surgery (*tummy tuck, face-lift, burned off moles, liposuction, etc.)?* ☐ No ☐ Yes

d.) Do you have any metal or plastic inside your body (*such as pins, clamps, plates, etc.)?* ☐ No ☐ Yes

e.) Do you have pierced ears or other body piercings? ☐ No ☐ Yes Tattoos? ☐ No ☐ Yes

6 Scars

Describe any scars on your body (major and minor ones):

7 Drugs

This is strictly confidential information. **Do you currently use recreational drugs?** ☐ No ☐ Yes

Check all that apply: ☐ marijuana ☐ cocaine ☐ heroin ☐ uppers ☐ downers Others: ______

How often? ______ Have you used recreational drugs in the past? ☐ No ☐ Yes If yes, for how long? ______

8 Stress

Please rate your current stress level (on a scale of 1 to 10, 10 being the highest stress): ______

What is the main reason(s) for your stress?: ______

If over level 5, what step(s) are you taking to reduce your stress level?: ______

9 Dental Work

Indicate how many of the following you have:

Silver fillings: ______ Gold crowns or inlays: ______ Root canals: ______ Root canals with BioCalex: ______

Composites (tooth-colored): ______ Stainless steel crowns or inlays: ______ Braces: ______ Bleeding Gums: ______

Extractions: ______ Porcelain crowns or inlays: ______ Posts: ______ Sensitive Teeth: ______

Bridgework: ______ DeGussa Porcelain crowns or inlays: ______ Implants: ______ Bad Bite: ______

Partial or full dentures: ______ Veneers: ______ Temporaries: ______ New cavities: ______

Have you had any teeth extracted (wisdom teeth, four bicuspid extraction etc.)?: ______

Have you had dental surgery (gum surgery, jaw surgery, etc.)?: ______

Do you need further dental work? ☐ No ☐ Yes If so, what?: ______

Health Overview

For the following questions, check the phrases that apply to you.

1 Sleep

How is your sleep?

☐ Restful ☐ Restless ☐ Hard to get to sleep ☐ Wake up often? ☐ Get up during the night? ☐ Bad dreams?

Other complaints?: ______

What time do you usually go to sleep?: ______ Number of hours of sleep per night?: ______

2 Digestion

How is your digestion?

☐ Adequate ☐ Poor ☐ Acid reflux ☐ Burp often ☐ Bloating ☐ Burning / pain in stomach

Other complaints?: ______

3 Urination

How are your daily urinations?

☐ every 2 to 3 hours ☐ too frequent ☐ sense of urgency ☐ too small amount ☐ too large amount

☐ burning ☐ dribbling ☐ up at night several times

Other complaints?: ______________________________

4 Bowels

How are your bowel eliminations?

How often?: ☐ 3 times daily ☐ once per day ☐ skip days **Amount:** ☐ normal ☐ too little ☐ too large

Consistency: ☐ normal ☐ too hard ☐ very soft ☐ diarrhea **Color:** ☐ brown ☐ black ☐ whitish

Other: ☐ lots of mucus ☐ lots of gas ☐ foul smell

Other complaints?:

5 Women Only

Are you pregnant? ☐ No ☐ Yes Are you breast-feeding? ☐ No ☐ Yes Do you have monthly periods? ☐ No ☐ Yes

Date of last menstrual period: ____________ Are you going through menopause? ☐ No ☐ Yes Have your periods stopped? ☐ No ☐ Yes

Had a hysterectomy? ☐ No ☐ Yes If so, when?: ____________

Menstrual Cycle

Are your monthly periods regular (28 day cycles)? ☐ No ☐ Yes Number of days of your menstrual flow?: ____________

Check any of the following symptoms you experience associated with your period:

☐ cramping ☐ bloating ☐ feeling weak ☐ mood swings ☐ cravings ☐ heavy bleeding ☐ back pain

☐ headaches ☐ bright red blood ☐ dark clotty blood

Other menstrual complaints?:

6 Exercise

What kind of exercise do you get?: ______________________________

How often?: ____________ For how long at a time?: ____________

7 Sunlight

Amount of natural sunlight you receive daily outside?: ______________________________

Amount of sunlight you receive daily <u>through windows</u>?: ____________ Hours spent daily under fluorescent lights?: ____________

Do you use Chromalux light bulbs at home?: ☐ No ☐ Yes At work?: ☐ No ☐ Yes

8 Eyewear

Do you wear contact lenses?: ☐ No ☐ Yes Glasses?: ☐ No ☐ Yes If so, how many hours per day?: ____________

Do your lenses have tints?: ☐ No ☐ Yes An anti-glare coating?: ☐ No ☐ Yes A scratch-resistant coating?: ☐ No ☐ Yes

9 Electromagnetic Exposure

How many hours do you spend daily:

Watching TV?: ____________ Working on a computer?: ____________ Talking on a phone?: ____________

Talking on a cellular phone?: ____________ Wearing a headset?: ____________ Wearing a hearing aid?: ____________

Wearing a wrist-watch (watch battery)?: ____________ Wearing a pager?: ____________ Riding in a car/truck/vehicle?: ____________

Near electrical equipment for long periods of time (*such as copy machines, high power lines, computers, etc.*)?: ____________

When you sleep, is your head within 10 feet of a plug-in clock (such as on a nightstand)?: ☐ No ☐ Yes

10 Clothing

How often do you wear 100% natural clothing (*cotton, ramie, wool, silk, or linen*)?: ____________

Synthetic clothing (*polyester, acrylic, nylon, rayon, etc.*)?: ____________

Blends (*natural fabric combined with synthetic*)?: ____________

11 Personal Care Products

List the brand names that you use: (*Please take time to complete this list.)*

Shampoo: ____________

Deodorant: ____________

Toothpaste: ____________

Soap: ____________

Hand/Body Lotion: ____________

Facial Cleanser/ Moisturizer: ____________

Hair Spray/ Gel: ____________

Personal (sexual) Lubricant: ____________

Contraceptive jelly/ spermicide: ____________

Hair Dye: ____________

Fingernail/ Toenail Polish: ____________

Shave Cream: ____________

Dish Washing Liquid/ Powder: ____________

Laundry Soap: ____________

Tub/Tile Cleaner: ____________

Glass Cleaner: ____________

All Purpose Cleaner: ____________

Perfume/ Cologne: ____________

Roach/ Ant Spray: ____________

Toilet Freshener: ____________

Hair Permanent: ____________

Face make-up/ Eye make-up: ____________

Other chemical exposure (*from yard, workplace, art chemicals, etc.*): ____________

12 Appliances

Check which of the following you use:

☐ Gas stove ☐ Electric stove ☐ Electric heater ☐ Electric blanket ☐ Water bed ☐ Turbo blend ☐ Microwave Oven

Air purifier (brand)?: ____________

Water purifier (brand)?: ____________

13 Cookware

What type of cookware do you use? (check all that apply):

☐ stainless steel ☐ aluminium ☐ iron ☐ teflon coated ☐ glass ☐ Ultrex

Other types: ______________________________

14 Shower Filter

What brand of shower filter do you use (*for chlorine protection*)?: ______________________________

When was your filter last changed?: ______________________________

15 Pets

Do you have pets?: ☐ No ☐ Yes If so, what kind/how many?: ______________________________

Are your pets allowed in the house?: ☐ No ☐ Yes On your bed?: ☐ No ☐ Yes

What do you feed your pet(s)?: ______________________________

Food Choices

Check each type of food that you eat often (once a week or more):

1. Pre-made foods: ☐ canned foods ☐ boxed cereals ☐ frozen dinners ☐ bottled or frozen juices ☐ take-out food

2. Red meat *(beef, pork, lamb)*: ☐ commercially grown ☐ naturally raised Brand: ______________________________

3. Chicken: ☐ commercially grown ☐ naturally raised Brand: ______________________________

4. Turkey: ☐ commercially grown ☐ naturally raised Brand: ______________________________

5. Fish: ☐ canned tuna ☐ fresh fish ☐ frozen fish ☐ at restaurants

6. Fresh vegetables: ☐ commercially grown *(store bought)* ☐ organically grown *(store bought)* ☐ organically grown *(direct from farmer)* ☐ from natural growers at farmer's market

7. Fresh fruit: ☐ commercially grown *(store bought)* ☐ organically grown *(store bought)* ☐ organically grown *(direct from farmer)* ☐ from natural growers at farmer's market

8. Whole grains: ☐ commercially grown *(store bought)* ☐ organic *(store bought)* ☐ organic *(direct from farmers)*

9. Whole beans: ☐ commercially grown *(store bought)* ☐ organic *(store bought)* ☐ organic *(direct from farmers)*

10. Eggs/ Butter: ☐ commercial eggs *(store bought)* ☐ organic eggs ☐ commercial butter ☐ organic butter

11. Milk: ☐ commercial milk ☐ organic pasteurized milk ☐ organic goat's milk ☐ good quality raw whole milk (such as Claravale)

12. Cheese: ☐ commercial cheese ☐ organic aged cheese *(store-bought)* ☐ recommended aged cheeses by Dr. Marshall

13. Other: ☐ commercial ketchup, mustard, spices ☐ commercial vinegar ☐ commercial olive oil ☐ PRL Olive Oil

Food Stressors

Please indicate how many times per week you consume the following foods:

Stimulants		Toxic Oils		Highly Heated Foods		Commercial Dairy	
Coffee (including decaf.):		Fried foods:		Bread *(store bought)*:		Cow's Milk:	
Black tea, caffeine drinks:		Fast food:		Crackers *(store bought)*:		Yogurt:	
Soft drinks (colas, etc):		Potato or corn chips:		Bagels *(store bought)*:		Ice Cream:	
Drinks with NutraSweet:		Roasted nuts:		Buns *(store bought)*:		Cottage Cheese:	
Alcohol (wine, beer, etc.):		Mayonnaise:		Pasta *(store bought)*:		Sour Cream:	
Chocolate:		Margarine:		Muffins *(store bought)*:		Cheese *(com.)*:	
Candy, pastries, sweets:		Peanut butter *(com.)*:		Cookies *(store bought)*:			

Food Habits

1 Eating Out Do you eat out at restaurants?: ☐ No ☐ Yes If yes, how often?: ______

Where?: ______

What type of food do you eat at restaurants?: ______

2 Home Meals Do you prepare meals at home?: ☐ No ☐ Yes If yes, how often?: ______

If yes, what type of food do you prepare?: ______

3 Meal Habits Do you: ☐ Skip meals often ☐ have irregular eating times ☐ eat food past 7PM

4 MSG Do you avoid food/ drinks that list "natural flavors" *(which means hidden MSG)* on the label?: ☐ No ☐ Yes

5 Water Do you drink tap water?: ☐ No ☐ Yes What brand of drinking water do you use?: ______

If you have a home water purifier, when was the cartridge last changed?: ______

Typical Diet

Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") PLEASE, BE HONEST!

BREAKFAST - Time eaten:

LUNCH - Time eaten:

DINNER - Time eaten:

SNACKS - Time eaten:

Bedroom/Sleep Considerations

1. Bedding Materials. What type of sheets and blankets do you use? (i.e. 100% cotton, silk, polyester, poly-blends, wool, etc.)

2. Mattress. What type of mattress do you sleep on? (such as box springs, synthetic, futon, latex, etc.)

3. Head Direction. What direction does the top of your head point when you sleep? (i.e. south, north, northwest, etc.)

4. Darkness - Do you sleep with the curtains drawn tightly (so the room is very dark) or is there considerable light in the room when you sleep?

5. Electrical Appliances. Is there a computer, TV or electrical appliance near your bed?

If so, how far away? ____________________

6. Clock-Radio. Do you sleep with a clock-radio near your head (within one to two feet)?

7. Windows. Do you sleep near a window?

If yes, what direction does the window face? ____________________

8. Alarm. Do you sleep with a whole-house alarm turned on (which uses infrared beams/sensors within the house)?

9. EMF Exposure. Do you sleep with your head at least one foot away from the wall?

Electrical Devices on Body

1. Hearing Aid. Do you wear a hearing aid? ☐ No ☐ Yes If yes, which ear(s)? ____________________

2. Watch. Do you wear a battery-operated watch? ☐ No ☐ Yes

3. Pacemaker. Do you wear a pacemaker? ☐ No ☐ Yes

4. Other. Do you wear any other electrically-powered devices on your body? ☐ No ☐ Yes If yes, what and where? ____________________

EMF Exposure

1. Cell Phone. Do you use a cell phone? ☐ No ☐ Yes

2. Cell Phone Tower. Do you live or work within 1/2 mile of a cell phone tower? ☐ No ☐ Yes

3. Transformers. Do you live or work within 100ft. or less of a power transformer (on a telephone pole)? ☐ No ☐ Yes

4. Pager. Do you wear a pager? ☐ No ☐ Yes If yes, how often? ____________________

Toxic Body Exposure

1. Nail Polish. Do you wear fingernail or toenail polish?

Have you ever worn fingernail or toenail polish?

If yes, for how long? ____________________

2. Toxic Chemicals. Have you ever had toxic chemicals spill on your body?

If yes, what? ____________________