

## 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:** \_\_\_\_\_ **M**  **F**  **Birthdate:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Marital Status:** S  M  D  W  **No. of Children B:** \_\_\_ **G:** \_\_\_ **Height:** \_\_\_ **Weight:** \_\_\_

**Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Mobile Phone:** (\_\_\_\_\_) \_\_\_\_\_

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:**(\_\_\_\_\_) \_\_\_\_\_

1. **Current Health Complaints:** Please rank your current ailments (on a scale of 1 to 10, 10 being most severe)  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. **Other Information:** Please list any history of chronic infections and how long you have known about them.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. **Medications:** Please list any you are currently taking and how long you've taken them (including birth control pills, aspirin, pain medication, etc)  
 \_\_\_\_\_  
 \_\_\_\_\_
  
4. **Please list all recent and any long term use of antibiotics, when taken and duration taken.**  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. **Did you have the usual childhood vaccines? Y/N**
  
6. **Do you smoke?** \_\_\_\_\_ **If yes, how much?** \_\_\_\_\_ **How long have you smoked?** \_\_\_\_\_  
**Do you drink?** \_\_\_\_\_ **If yes, how much?** \_\_\_\_\_ **How often?** \_\_\_\_\_  
*(This is strictly confidential information)* **Have you used recreational drugs? Y/N**  
**Do you still use them? Y/N** **For how long?** \_\_\_\_\_ **How often?** \_\_\_\_\_
  
7. **Have you ever had full-body anesthesia? Y/N** **When?** \_\_\_\_\_ **Do you have a pacemaker? Y/N**
  
8. **Have you ever had anaphylactic shock? Y/N** **When?** \_\_\_\_\_ **To what allergen:** \_\_\_\_\_  
**Do you have any other allergies:** \_\_\_\_\_

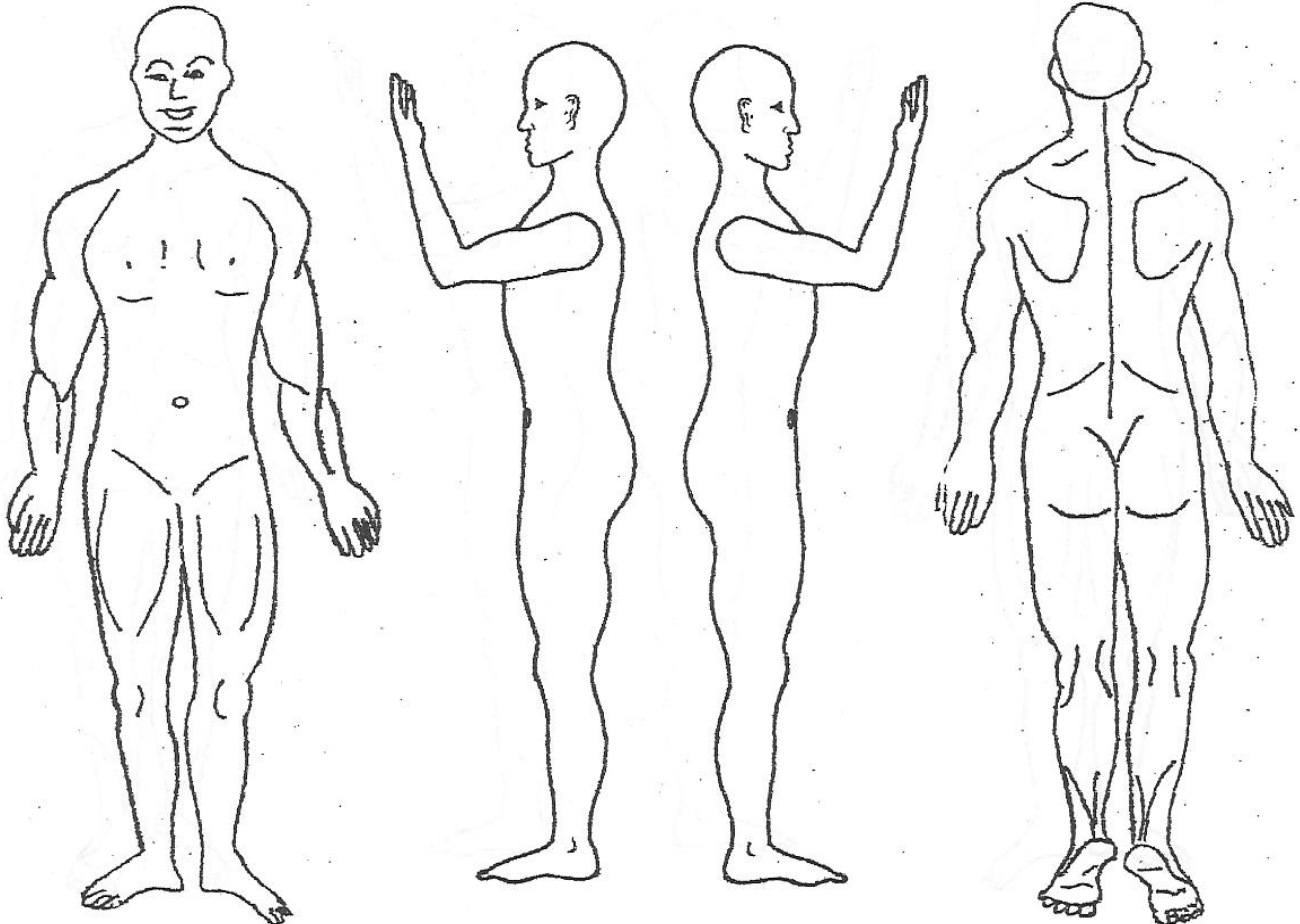
9a. Please list all surgeries, operations, traumas, car accidents, injuries you've had *SINCE BIRTH*.

Please include elective surgeries such as breast implantations, tummy tuck, face-lift, burned off moles, etc. *Don't Forget C-sections, Vaccination scars, episiotomies, earring punctures, tattoos, facelift scars, previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.*

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_
- E. \_\_\_\_\_
- F. \_\_\_\_\_
- G. \_\_\_\_\_
- H. \_\_\_\_\_
- I. \_\_\_\_\_
- J. \_\_\_\_\_
- K. \_\_\_\_\_
- L. \_\_\_\_\_

9b. For the numbered list, please record your primary concerns, any aches, and/or pains.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_
- 11. \_\_\_\_\_
- 12. \_\_\_\_\_



**10. Stress: Please rate your current stress level** (on a scale of 1 to 10, 10 being the highest) \_\_\_\_\_  
 What is the main reason(s) for your stress? \_\_\_\_\_  
 If you're above level 5, what steps are you taking to alleviate your stress? \_\_\_\_\_

**11. Dental Work:** Please indicate how many of the following you have:

METAL FILLINGS: _____	CROWNS OR INLAYS: _____	IMPLANTS GUM: _____
WHITE FILLINGS: _____	[CIRCLE] ( <i>GOLD, STAINLESS STEEL,</i>	SENSITIVE GUMS: _____
EXTRACTIONS: _____	<i>PORCELAIN, DEGUSSA,)</i>	BRACES: _____
BRIDGEWORK: _____	ROOT CANALS: _____	BAD BITE: _____
VENEERS: _____	PARTIAL OR FULL DENTURES: _____	DENTURES? _____

Have you had dental surgery ? [yes/no] Do you need further dental work? [yes/no] If so, what? \_\_\_\_\_

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**12. Family History:** What is your Blood Type? \_\_\_\_\_ Were you breast fed as a child? \_\_\_\_\_ What is your inherited ethnic background? Mother's side \_\_\_\_\_ Father's side: \_\_\_\_\_

**13. Please indicate which of the following you or an immediate family member has or has had. Please indicate which family member if not you.**

ARTERIOSCLEROSIS _____	HIGH BLOOD PRESSURE _____
ARTHRITIS _____	HYPER/HYPO-THYROIDISM _____
ASTHMA _____	KIDNEY DISEASE _____
CANCER _____	NEUROLOGICAL DISEASE _____
DIABETES _____	STOMACH ULCER _____
EPILEPSY _____	PERIODONTAL DISEASE _____
GLAUCOMA _____	TUBERCULOSIS _____
GOUT _____	OBSESITY _____
HEART DISEASE/ STROKE _____	SENILITY _____

**14. Check the following illnesses/ problems you now have or have had. If it is a current problem, please indicate with a star (\*)**

_____ ABSCESSSES	_____ BULIMIA	_____ HERNIATED DISC	_____ OSTEOPENIA
_____ ACNE	_____ DIPHERIA	_____ HERPES	_____ OSTEOPOROSIS
_____ AIDS	_____ DIVERTICULITIS	_____ HIGH BLOOD PRESSURE	_____ PANCREATITIS
_____ ALCOHOL ADDICTION	_____ DRUG ADDICTION	_____ HIVES	_____ PERSISTENT COUGH
_____ ALLERGIES	_____ EAR INFECTIONS	_____ INSOMNIA	_____ PNEUMONIA
_____ ALOPECIA	_____ ECZEMA	_____ JAUNDICE	_____ POLIO
_____ ANEMIA	_____ EMPHYSEMA	_____ KIDNEY STONES	_____ PSORIASIS
_____ ANOREXIA	_____ ENDOMETRIOSIS	_____ LIVER DISEASE	_____ RHEUMATIC FEVER
_____ ATTEMPTED SUICIDE	_____ EXCESSIVE FATIGUE	_____ LOW BLOOD PRESSURE	_____ RHEUMATOID ARTHRITIS
_____ ARTERIOSCLEROSIS	_____ EYE DISEASE	_____ LUPUS	_____ SCARLET FEVER
_____ BACK PROBLEMS	_____ FAINTING/DIZZINESS	_____ NUMBNESS	_____ SCIATICCA

**15. Do you have current lab (blood, saliva, stool, urine) work? If so, please bring a copy with you.**

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# HEALTH OVERVIEW

— FOR OFFICE USE ONLY —

1. **SLEEP:** What time do you usually go to sleep? \_\_\_\_\_  
Number of hours of sleep per night: \_\_\_\_\_  
How is your sleep? [**Circle:** *restless, hard to fall asleep, bad dreams.*]  
How do you feel when you wake up? *Rested/Tired*  
Do you get 5 continuous hours of sleep per night? \_\_\_\_\_  
Wake up during the night? Y/N If so, what time \_\_\_\_\_  
Do you have insomnia? Y/N  
Other complaints? \_\_\_\_\_

2. **DIGESTION:** How is your digestion?  
[**Circle:** *adequate, poor, acid reflux, burp often, bloating, burning/pain.*]  
Do you have gas? Bloating? Pain after eating? \_\_\_\_\_  
Other complaints? \_\_\_\_\_

3. **URINATION:** How is your daily urination?  
[**Circle:** *every 2-3 hours, 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?** *3times daily, once a 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? \_\_\_\_\_

NOTE: GUT OVERLOAD?

5. **WOMEN ONLY:** Are you pregnant? \_\_\_\_\_ Are you breast-feeding? \_\_\_\_\_ Do you have monthly periods? \_\_\_\_\_  
Date of last menstrual period? \_\_\_\_\_ Are you going through menopause? \_\_\_\_\_ Have your periods stopped? \_\_\_\_\_  
Had a hysterectomy? \_\_\_\_\_ If so, when? \_\_\_\_\_

**Menstrual Cycle:** Are your monthly periods regular (28 days)? \_\_\_\_\_ Number of days of your menstrual flow? \_\_\_\_\_  
[**Circle any of the following symptoms associated with your period:** *cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood.*]  
Other complaints? \_\_\_\_\_

**Pregnancy:** Have you ever been pregnant? \_\_\_\_\_ Number of births \_\_\_\_\_  
Please list any complications/ problems with your pregnancy(ies) or delivery(ies): \_\_\_\_\_

6. **EXERCISE:** What kind of exercise do you do? \_\_\_\_\_  
How often? \_\_\_\_\_ For how long at a time? \_\_\_\_\_

7. **CIRCULATION:** Are your hands and feet especially colder than your body? Y/N Are they tingly? Y/N Sweaty? Y/N

8. **SUNLIGHT:** How much sunlight do you receive daily outside? \_\_\_\_\_ How much through windows? \_\_\_\_\_

9. **EYEWEAR:** Do you wear contact lenses? \_\_\_\_\_ How many hours per day? \_\_\_\_\_ Glasses? \_\_\_\_\_ How many hours per day? \_\_\_\_\_ Do your lenses have tint? \_\_\_\_\_ An anti-glare coating? \_\_\_\_\_ A scratch-resistant coating? \_\_\_\_\_

10. **ELECTROMAGNETIC EXPOSURE:** *how many hours do you spend daily...*

Watching TV? \_\_\_\_\_ Working on a computer? \_\_\_\_\_ Talking on a phone? \_\_\_\_\_ On a cell phone? \_\_\_\_\_ Wearing a pager? \_\_\_\_\_ A headset? \_\_\_\_\_ Wearing a battery-operated wrist-watch? \_\_\_\_\_ Riding a vehicle? \_\_\_\_\_  
Near electrical equipment? \_\_\_\_\_ When you sleep, is your head 10-feet away from electric devices such as a radio-alarm clock? \_\_\_\_\_ At least 1-ft from the wall? \_\_\_\_\_ Do you have fluorescent lights? Y/N How many hours do you spend under them? \_\_\_\_\_ Is your cell phone protected? Y/N Are you interested in protecting your brain? Y/N

# NUTRITION OVERVIEW

1. pH \_\_\_\_\_ Zinc \_\_\_\_\_

2. **WEIGHT:** **% Fat:** \_\_\_\_\_ **BMR:** \_\_\_\_\_  
 Usual Body Weight: \_\_\_\_\_ Desired Body Weight: \_\_\_\_\_  
 Lowest Body Weight: \_\_\_\_\_ Highest Body Weight: \_\_\_\_\_

3. **MEASUREMENTS:** (— FOR OFFICE USE ONLY —)  
 Chest: \_\_\_\_\_ Waist: \_\_\_\_\_ Oblique: \_\_\_\_\_  
 Thigh R/L: \_\_\_\_\_ Arm R/L: \_\_\_\_\_

4. **VITAMINS:** Please list any vitamins or supplements you are currently taking. Ex: multi's, calcium, fish oils.


5. **FOOD CHOICES:** Please indicate the foods you eat.

- a. **Fish:** Varieties \_\_\_\_\_ Canned? Y/N Frozen? Y/N
- b. **Oils:** Varieties \_\_\_\_\_ Do they come in a dark bottle? Y/N
- c. **Red Meat:** Varieties \_\_\_\_\_
- e. *Please indicate the number of times per week you eat the following:*

	<i>circle</i>	<i>#/week</i>		<i>circle</i>	<i>#/week</i>
<b>Chicken</b>	Commercial/ Organic		<b>Cheeses</b>	Commercial/ Organic	
<b>Turkey</b>	Commercial/ Organic		<b>Butter</b>	Commercial/ Organic	
<b>Red Meat</b>	Commercial/ Organic		<b>Vegetables</b>	Commercial/ Organic/ Frozen/ Canned	
<b>Eggs</b>	Commercial/ Organic		<b>Fruit</b>	Commercial/ Organic/ Frozen/ Canned	
<b>Milk</b>	Commercial/ Organic		<b>Whole Grains, Beans</b>	Commercial/ Organic	

6. **FOOD STRESSORS:**

- a. Do you chew gum often? \_\_\_\_\_ Suck on candy? \_\_\_\_\_ Eat mints? \_\_\_\_\_
- b. Do you eat boxed cereals, frozen dinners, bottled or frozen juices, take-out food Y/N \_\_\_\_\_
- c. *Please indicate the number of times per week you eat the following:*

Stimulant	Toxic Oils	Commercial Dairy	Highly Heated Foods
Coffee	Fried Foods	Milk	Bread
Black tea	Fast Food	Yogurt	Crackers
Soft drinks	Potato Chips	Ice Cream	Bagels
Aspartame	Roasted nuts	Cottage Cheese	Buns
Alcohol	Mayonnaise	Sour Cream	Pasta
Chocolate	Margarine	Cheeses	Muffins
Pastries	Peanut butter	Cream Cheese	Cookies