FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help me 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: _____

Email:_____

Height: _____ Weight: _____ Marital Status: S M D W No. of children: _____

Daytime phone: (_____)_____ Evening phone: (_____) _____

Blood Type:_____

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 me 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? _____ If yes, how much? _____ How long have you smoked?_____

Do you frequently breathe second-hand smoke from others who are smoking (either at work or at home)?_____

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

_____
_____
_____

a.) Have you had elective surgery (tummy tuck, face-lift, burned off moles, liposuction, laparoscopy etc.)?_____
_____

6. Scars Please describe any scars on your body (major and minor ones):_____
_____

7. Drugs: this is strictly confidential information. Do you currently use recreational drugs? _____ [Circle all that apply: marijuana, cocaine, heroin, uppers, downers] Others:_____ How often?_____

Have you used recreational drugs in the past?_____ 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: Please tell me about your dental history:_____
_____
_____

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?_____ If so, what?_____

Health Overview

For the following questions, please circle or mark the phrases that apply to you.

1. Sleep: How is your sleep? [Circle: restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams]

Other symptoms? _____

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

2. Digestion: How is your digestion? [Circle: adequate, poor, acid reflux, burp often, bloating, burning/pain in stomach]

Other symptoms?_____

3. Urination: How are your daily urinations? [Circle: every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times]

Other symptoms?_____

4. Bowels: How are your bowel eliminations? Circle or mark the phrases that apply: [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 symptoms?_____

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 day cycles)?_____

Number of days of your menstrual flow?_____

Circle or mark any symptom 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 symptoms?_____

6. Exercise What kind of exercise do you do?_____

How often?_____ For how long at a time?_____

7. Sunlight Amount of natural sunlight you receive daily outside?_____ Amount of sunlight you receive daily through windows?_____ Hours spent daily under fluorescent lights?_____ ___

Diet - Circle or mark all that apply

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food

2. Red meat (beef, pork, lamb): a) commercially grown b) naturally raised (Brand:_____)

3. Chicken: a) commercially grown b) naturally raised (Brand:_____)

4. Turkey: a) commercially grown b) naturally raised (Brand:_____)

5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants

6. Fresh vegetables: a) commercially grown (store-bought) b) organically grown (store-bought)

c) Organically grown (direct from farmer)

7. Fresh fruit: a) commercially grown (store-bought) b) organically grown (store-bought)

c) Organically grown (direct from farmer)

8. Whole grains: a) commercially grown (store-bought) b) organic (store-bought) c) organic (direct from farmer)

9. Whole beans: a) commercially grown (store-bought) b) organic (store-bought) c) organic (direct from farmer)

10. Eggs/ Butter: a) commercial eggs (store-bought) b) naturally grown eggs c) commercial butter d) natural butter

11. Milk: a) commercial milk b) organic pasteurized milk c) organic goat's milk d) good quality, raw whole milk

12. Cheese: a) commercial cheese b) organic cheese (store-bought) c) aged cheeses

13. Condiments: a) commercial salt and/or pepper b) pink sea salt (PRL) c) artificial sweeteners (Equal, Sweet 'N Low, Coffeemate, etc.) d) commercial ketchup or mustard e) commercial vinegar f) commercial olive oil g) other

Food Choices

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

Commercial Dairy, Coffee (including decaf.), Fried foods, Cow's Milk, Bread (store-bought), Black tea, Caffeine drinks, Fast food, Yogurt, Crackers (store-bought), Soft drinks (colas, etc.), Potato or corn chips, Ice cream, Bagels (store-bought), Drinks with NutraSweet, Roasted nuts, Cottage cheese, Buns (store-bought), Alcohol (wine, beer, etc.), Mayonnaise, Sour cream, Pasta (store-bought), Chocolate, Margarine, Cheese (commercial), Muffins (store-bought), Candy, pastries, sweets, Peanut butter (commercial), Cookies (store-bought)

1. Eating Out Do you eat out at restaurants?_____ If yes, how often?_____ _____
Where?_____

2. Home Meals Do you prepare meals at home?_____ If so, how often?_____

If yes, what type of food do you prepare?_____

3. Meal Habits Do You: [circle] a) skip meals often b) have irregular eating times c) eat food past 7 PM

4. Water Do you drink tap water?_____What brand of drinking water do you use?_____

If you have a home water purifier, what type do you use?_____

BREAKFAST (Typical time eaten:_____)

LUNCH (Typical time eaten:_____)

DINNER (Typical time eaten:_____)

SNACKS (Typical time eaten:_____)

Typical Diet

Please list below your typical diet for the last few weeks. Please be as detailed as possible. PLEASE BE HONEST!

_____
_____
_____

Personal Health Goals

1. Do you want to lose weight?_____ If so, how much?_____

2. How important is your health to you, on a scale from 1 – 10 (1 = lowest; 10 = the highest importance)?

_____

3. How much confidence do you have in medical drugs, on a scale from 1- 10 (1 = low; 10 = high confidence)? _____

4. List any nutritional supplements that you regularly take:

_____
_____

6. What best describes your diet overall? Check all that apply: (Please be honest.)

__ mostly eat out (fast food)

__ mostly eat out (but try to eat healthier items)

__ eat whatever is available

__ occasional binges

__ would never give up meat

__ eat a lot of fresh food (very little from cans, boxes)

__ mostly homemade meals

__ vegetarian

__ eat mostly organic

__ eat a lot of raw food

__ in transition to eating better

7. What are your specific health goals? (What do you really want?)

_____

8. How far are you willing to commit to achieve your health goals? (Please be honest.)

__ don't really want to change much

__ willing to change some

__ willing to change a reasonable amount

__ willing to do whatever it takes

IMPORTANT: By signing below, I understand that the suggested nutritional program and dietary information is not intended as primary therapy for any disease or symptom. My intention is to find a good nutritional program that will assist me in changing my habits and establishing a new lifestyle in order to build good health naturally. I understand that this dietary health program is not for the diagnosis cure, mitigation, treatment, or prevention of disease; this is an adjunctive schedule of nutrients solely provided to upgrade the quality of foods in my diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body.

I understand that the natural health consultant I am visiting is not a medical doctor and does not treat or diagnose medical conditions; that this is not a replacement for medical counseling; that if I have a medical condition, I will seek a qualified medical professional. **I understand that it is my personal decision whether or not to follow the natural health suggestion offered.**

_____

Signature

_____

Date