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:** __________________

Height: _______ **Weight:** _______ **Marital Status:** **S ☐ M ☐ D ☐ W ☐** **No. of children:** _________

Daytime phone: (_____)______________________ **Evening phone:** (______) ____________________

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?** _______ **If yes, how much?** ________ **How long have you smoked?**______________

Do you frequently breathe the 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 ever had full-body anesthesia (i.e., *to remove tonsils, wisdom teeth, etc.*)?______________________________

b.) Do you have breast implants?_________ Other surgical implants or prostheses?______________________________

c.) Have you had elective surgery *(tummy tuck, face-lift, burned off moles, liposuction, etc.)*?__________________________

d.) Do you have any metal or plastic inside your body *(such as pins, clamps, plates, etc.)*?____________________________

e.) Do you have pierced ears or other body piercings?____________________________ Tatoos?______________________

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?** ______ *[**Circle:** 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 **Indicate how many of the following you have:**

Silver fillings _____	Gold crowns or inlays _____	Root canals _____	Braces _____
Composites *(tooth-colored)* _____	Stainless steel crowns or inlays _____	Root canals with EndoCal _____	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 (widsom 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, circle 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 complaints? ______
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 complaints?______

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 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?______ 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 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 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?__________ Do you use Chromalux light bulbs at home?__________ At work?____________

8. Eyewear Do you wear contact lenses?________ Glasses?_______ If so, how many hours per day?___________
Do your lenses have tints?_________ An anti-glare coating?________ A scratch-resistant coating?_________

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 pager? _____ Wearing a headset? _____ Wearing a wrist-watch *(with battery)*? ____ Wearing a hearing aid? ______
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 nite stand)? _________

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/Spermacide? ____________________
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 *Circle 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? *[**Circle**: stainless steel, aluminum, iron, teflon-coated, glass, Premier Waterless Cookware]*
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 a pet(s)?__________ If so, what kind/how many?____________________
Is it allowed in the house?__________ On your bed?__________ What do you feed your pet(s)?____________________

Food Choices *Circle each type of food that you eat often (once a week or more):*

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 farmers)* d) from natural growers at a farmer's market
7. Fresh fruit: a) commercially grown *(store-bought)* c) organically grown *(store-bought)* c) organically grown *(direct from farmer)* d) from natural growers at a farmer's market
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) organic eggs c) commercial butter d) organic 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 aged cheese *(store-bought)* c) recommended aged cheeses by Dr. Marshall
13. Other: a) commercial ketchup, mustard, spices b) commerical vinegar c) commercial olive oil d) PRL Olive Oil

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

Stimulants		Toxic Oils		Commercial Dairy		Highly Heated Foods	
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)*	

Food Habits

1. Eating Out Do you eat out at restaurants?________ If yes, how often?______________ Where?__________________
What type of food do you eat at restaurants?____

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. MSG Do you avoid food/drinks that list "natural flavors" *(which means hidden MSG)* on the label?________

5. Water Do you drink tap water?______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 to you use?

   ____

   (i.e., 100% cotton, silk, polyester, poly-blends, wool, etc.)

   What type of pillow do you use?______________

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?______________________

   Are any electrical appliances left on in the room when you sleep (such as a TV or computer)?__________

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? __________
   If yes, which ear(s)? ______________________

2. Watch. Do you wear a battery-operated watch?

   ____

3. Pacemaker. Do you wear a pacemaker? _________

4. Other. Do you wear any other electrically-powered devices on your body? ______________________
   If yes, what and where? ______________________

EMF Exposure

1. Cell Phone. Do you use a cell phone? ____________
   If yes, how often? ______________________

2. Cell Phone Tower. Do you live or work within 1/2 mile of a cell phone tower? ______________________

3. Transformers. Do you live or work within 100 ft. or less of a power transformer (on a telephone pole)?

   ____

4. Pager. Do you wear a pager? ______________
   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? ______________________

R07-1219

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. How much confidence do you have in your body's ability to heal itself (if given the right nutrients/natural therapies), on a scale from 1 to 10 (1 = low; 10 = high confidence)? __________

5. List any nutritional supplements that you regularly take: ______________________________________

____

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

__ 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

9. How much money do you spend per month on your health, out of pocket? ______________________

10. How long do you want to live? (Check all that apply.)

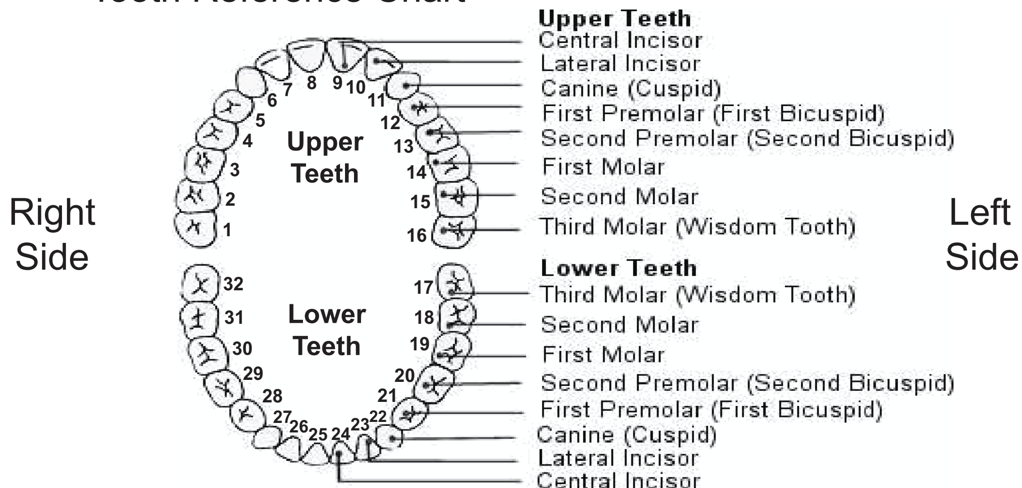
__ age 60-70
__ age 70-80
__ age 80-90
__ age 90 - 100
__ age 100+

__ as long as I'm healthy
__ as long as I have been granted
__ until I complete my mission (purpose) on earth
__ only if my significant other is still alive also
__ forever
__ it's already enough

Dental History Chart

Name: ________________________________ Date: ____________________

Tooth Reference Chart

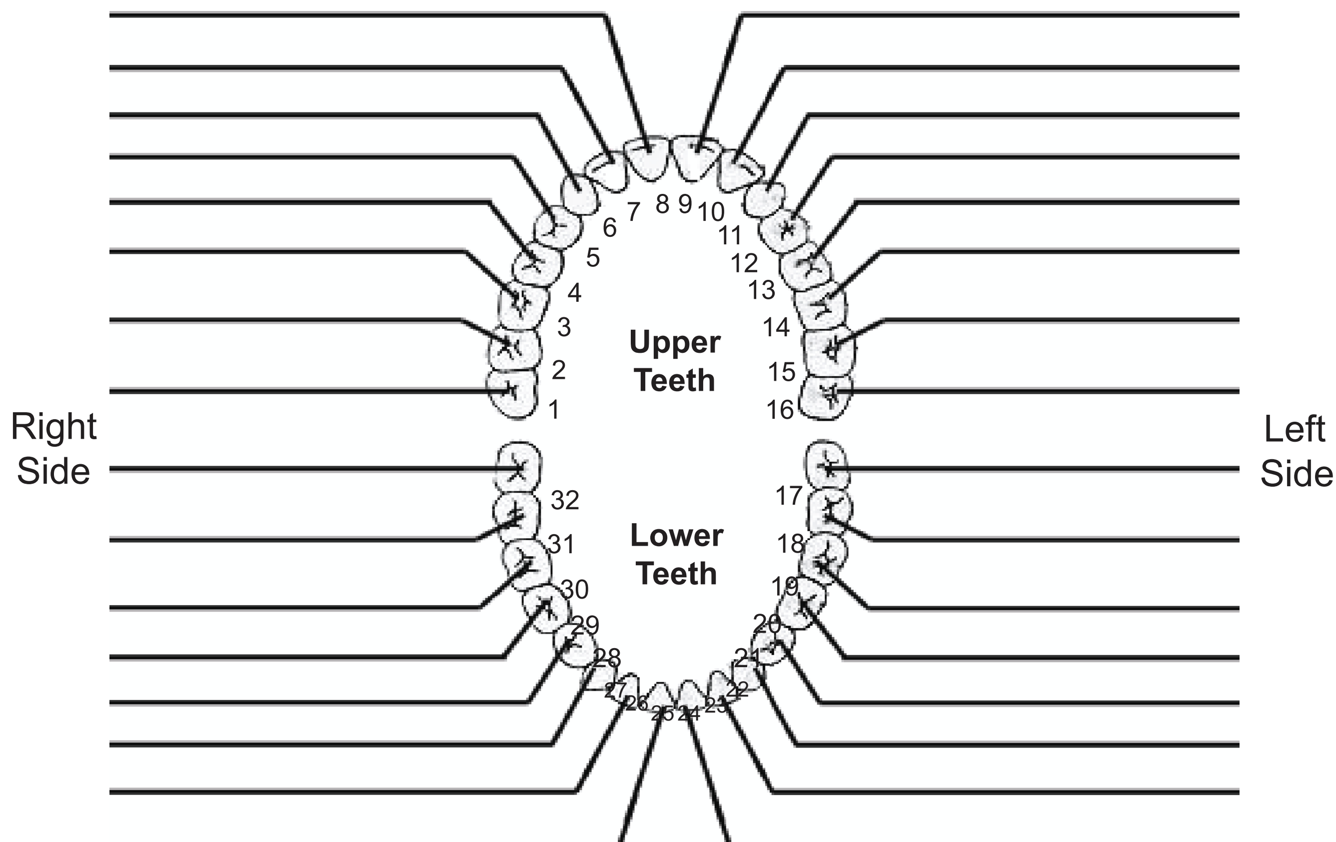


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example Chart on back.**

Please use the following descriptors when filling in the chart:

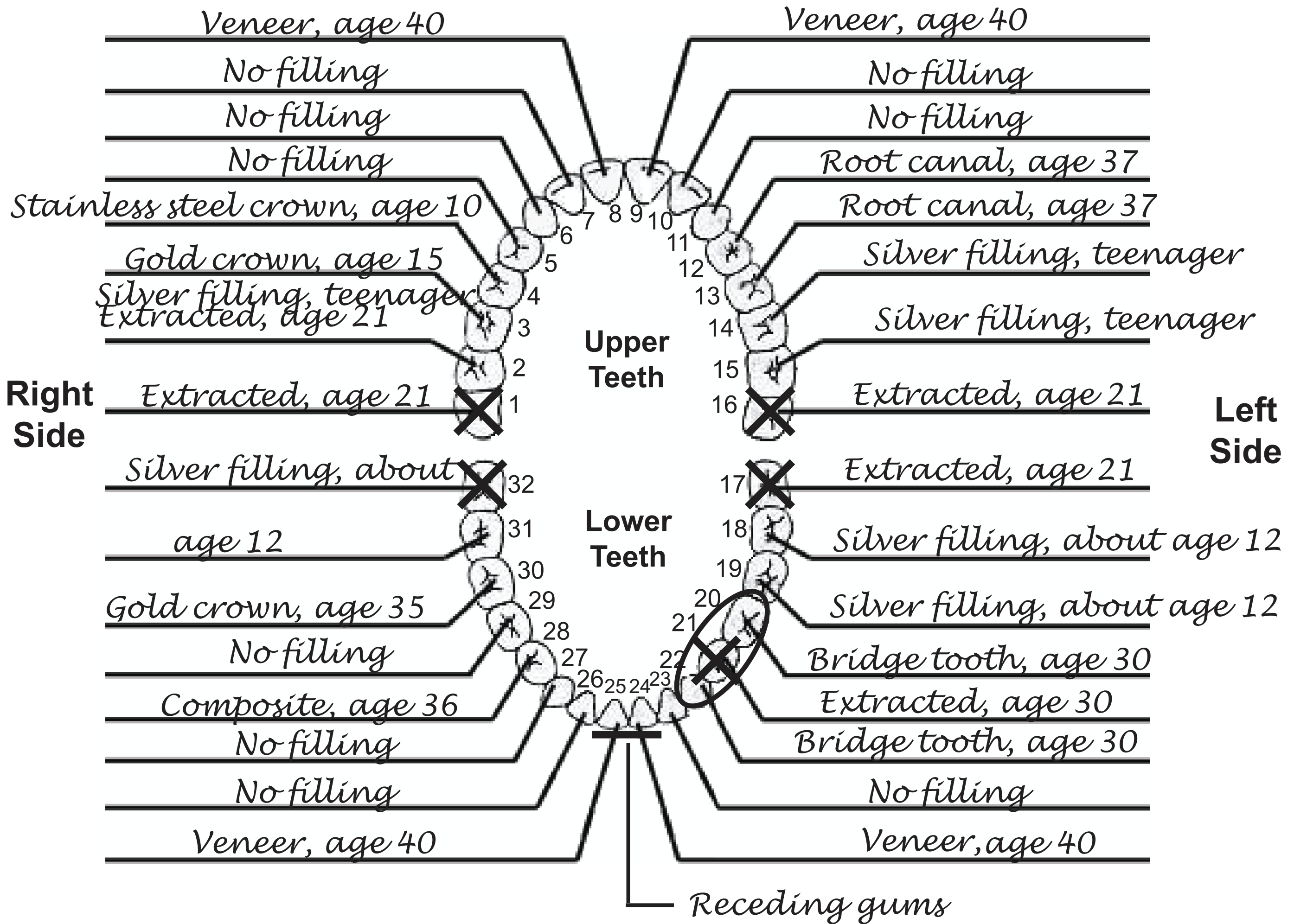
- Silver filling
- Composite filling *(plastic-like filling)*
- Gold crown
- Stainless steel crown
- Root canal
- Post (in root canal)
- Veneers
- Bridge *(circle teeth with bridge attached)*
- Partial denture
- Full denture
- Extracted tooth *(write next to X'd out tooth)*
- No filling

Gum Concerns: please make a line at the base of any teeth that have gum problems and indicate what type of concern, such as deep pockets, receding gums, bleeding gums, etc.



Example Dental Chart

Name: _Den Tall_____ **Date:** _4-10-07_

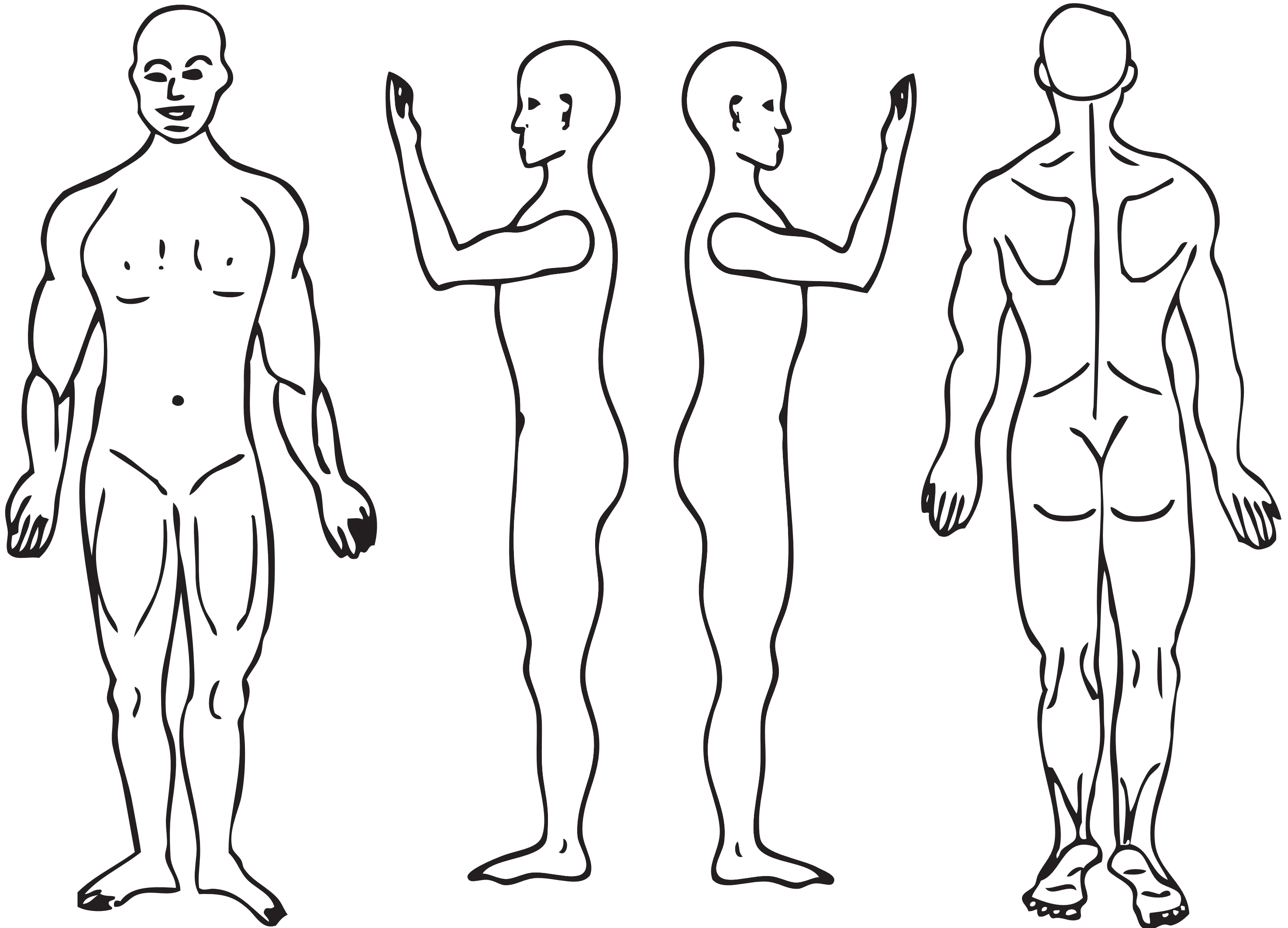


R06-0201

Scar/Trauma Chart

Name: ____

Date: __________________



Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, all injection sites (no matter how long ago), old burn areas, etc.

All Trauma Areas. Please put a red X where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988.")

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