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?**_____

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

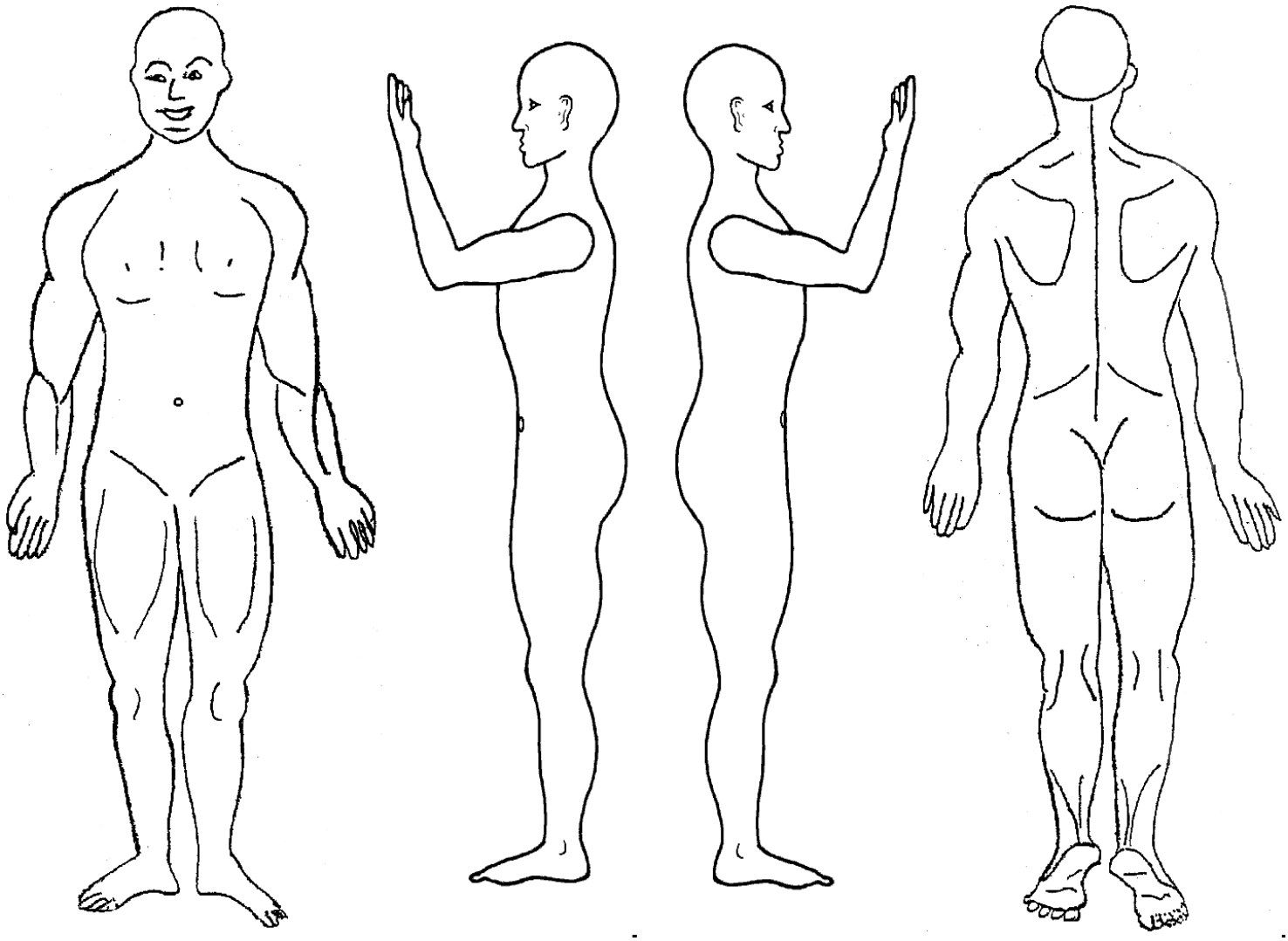
Please indicate how many times per week you consume the following foods:

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)*	

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, 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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