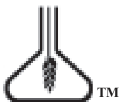


FIRST TIME EVALUATION

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, widom 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 BioCalex _____	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, 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 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 (such as Claravale)
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 Stressers

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?_________________________________

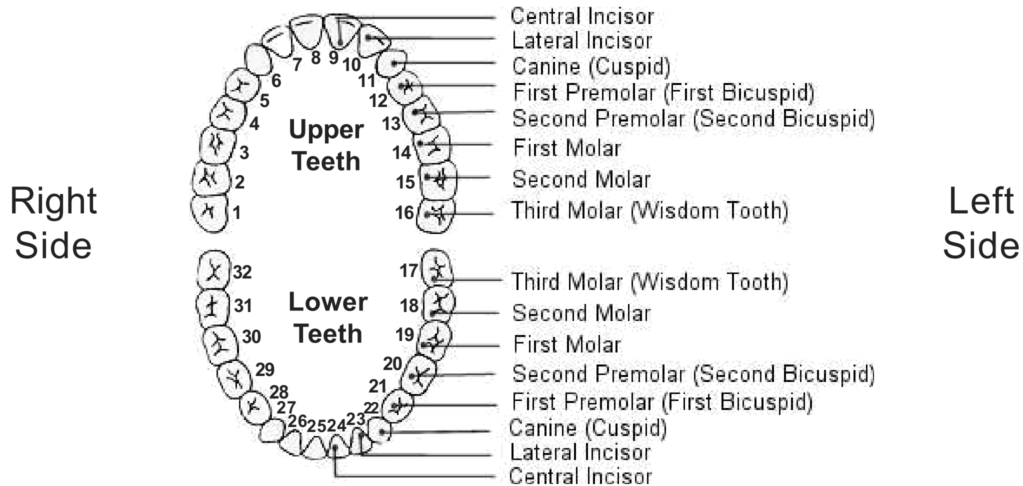
Rev. 4/25/05

Dental History Chart

Name: ______________________________ Date: ________________

Tooth Reference Chart

Right Side



Left Side

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
- 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.

Right Side

Upper Teeth

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

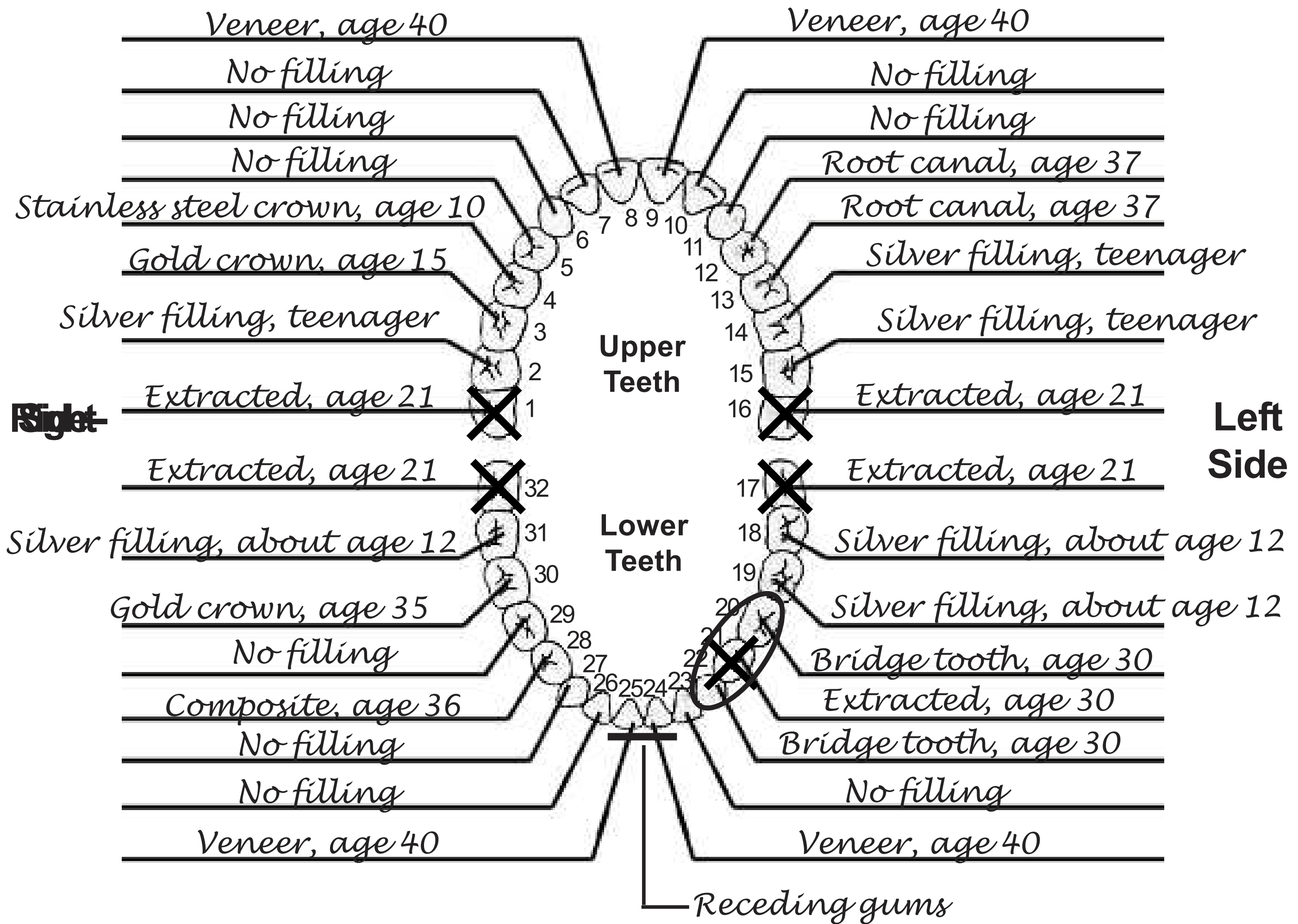
Lower Teeth

17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

Left Side

Example Dental Chart

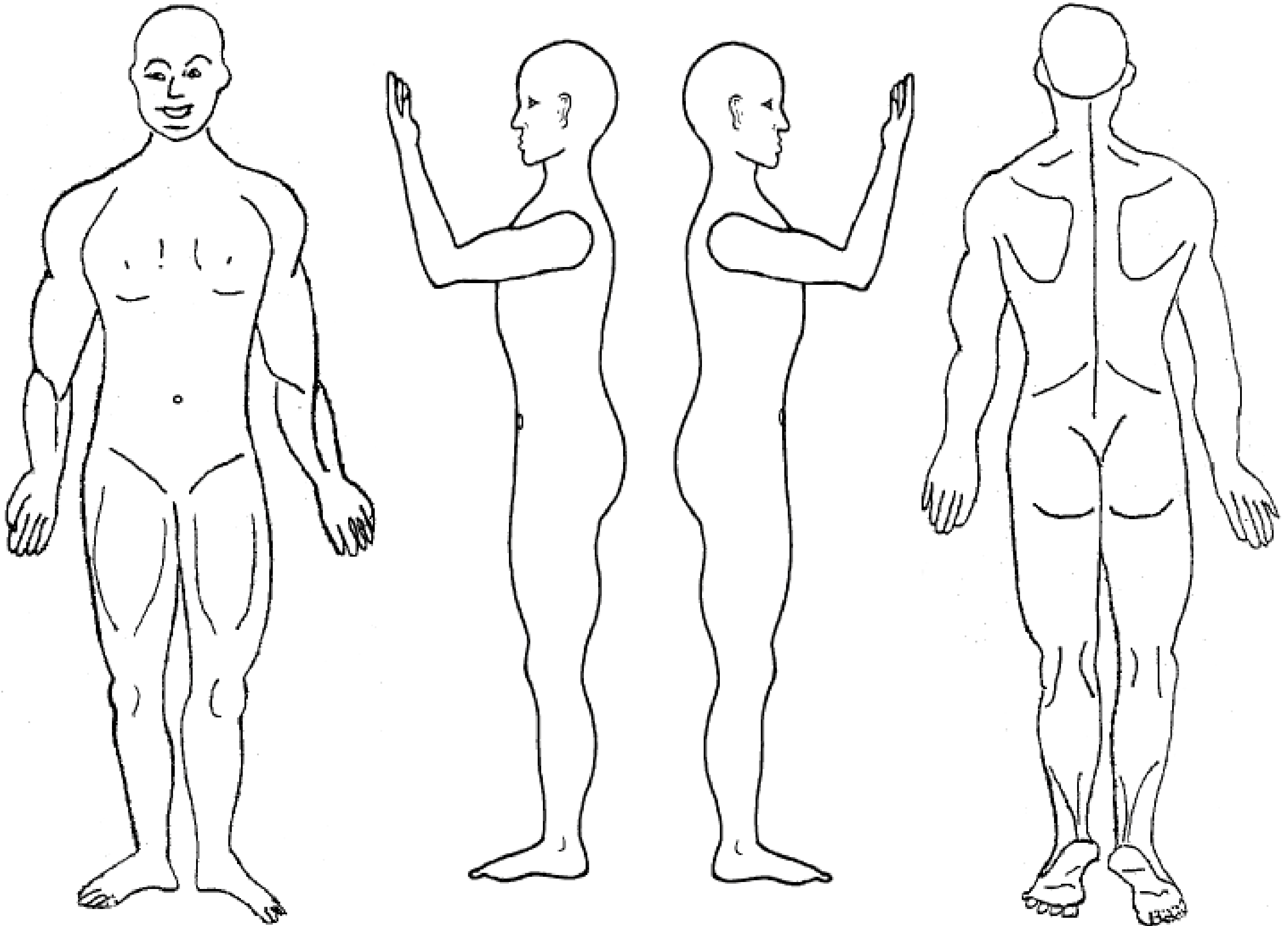
Name: _Den Tall_____ Date: _4-10-04_



Scar/Trauma Chart

Name: ____

Date: __________________



Directions

<u>All Scars</u>. 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, etc.

<u>All Trauma Areas</u>. 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.

<u>Internal Metal</u>: 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.

<u>Date of injury and type of injury</u>. 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")

Rev 4-25-05