



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? _____ Tattoos? _____

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 (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, 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? _____	Shave Cream? _____
Deodorant? _____	Dish Washing Liquid/Powder? _____
Toothpaste? _____	Laundry Soap? _____
Soap? _____	Tub/Tile Cleaner? _____
Hand/Body Lotion? _____	Glass Cleaner? _____
Facial Cleanser/Moisturizer? _____	All Purpose Cleaner? _____
Hair Spray/Gel? _____	Perfume/Cologne? _____
Personal (sexual) Lubricant? _____	Roach/Ant Spray? _____
Contraceptive jelly/spermicide? _____	Toilet Freshener? _____
Hair Dye? _____	Hair Permanent? _____
Fingernail/Toenail Polish? _____	Face make-up/ Eye make-up? _____
Other chemical exposure <i>(from yard, workplace, art chemicals, etc.)</i> ? _____	

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)*:

- Pre-made foods:** a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food
- Red meat (beef, pork, lamb):** a) commercially grown b) naturally raised (Brand: _____)
- Chicken:** a) commercially grown b) naturally raised (Brand: _____)
- Turkey:** a) commercially grown b) naturally raised (Brand: _____)
- Fish:** a) canned tuna b) fresh fish c) frozen fish d) at restaurants
- 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
- 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
- Whole grains:** a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic *(direct from farmer)*
- Whole beans:** a) commercially grown *(store-bought)* b) organic *(store-bought)* c) organic *(direct from farmer)*
- Eggs/ Butter:** a) commercial eggs *(store-bought)* b) organic eggs c) commercial butter d) organic butter
- Milk:** a) commercial milk b) organic pasteurized milk c) organic goat's milk d) good quality, raw whole milk
- Cheese:** a) commercial cheese b) organic aged cheese *(store-bought)* c) recommended aged cheeses by Dr. Marshall
- Other:** A) commercial ketchup, mustard, spices b) commercial 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 <i>(including decaf.)</i>	Fried foods	Cow's Milk	Bread <i>(store-bought)</i>
Black tea, caffeine drinks	Fast food	Yogurt	Crackers <i>(store-bought)</i>
Soft drinks <i>(colas, etc.)</i>	Potato or corn chips	Ice cream	Bagels <i>(store-bought)</i>
Drinks with NutraSweet	Roasted nuts	Cottage cheese	Buns <i>(store-bought)</i>
Alcohol <i>(wine, beer, etc.)</i>	Mayonnaise	Sour cream	Pasta <i>(store-bought)</i>
Chocolate	Margarine	Cheese <i>(commercial)</i>	Muffins <i>(store-bought)</i>
Candy, pastries, sweets	Peanut butter <i>(commercial)</i>		Cookies <i>(store-bought)</i>

Food Habits

- Eating Out** Do you eat out at restaurants? _____ If yes, how often? _____ Where? _____
What type of food do you eat at restaurants? _____
- Home Meals** Do you prepare meals at home? _____ If so, how often? _____
If yes, what type of food do you prepare? _____
- Meal Habits** Do You: [circle] a) skip meals often b) have irregular eating times c) eat food past 7 PM
- MSG** Do you avoid food/drinks that list "natural flavors" (*which means hidden MSG*) on the label? _____
- 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? _____