



# 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 (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 *(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) commercial vinegar    c) commercial olive oil    d) PRL Olive Oil

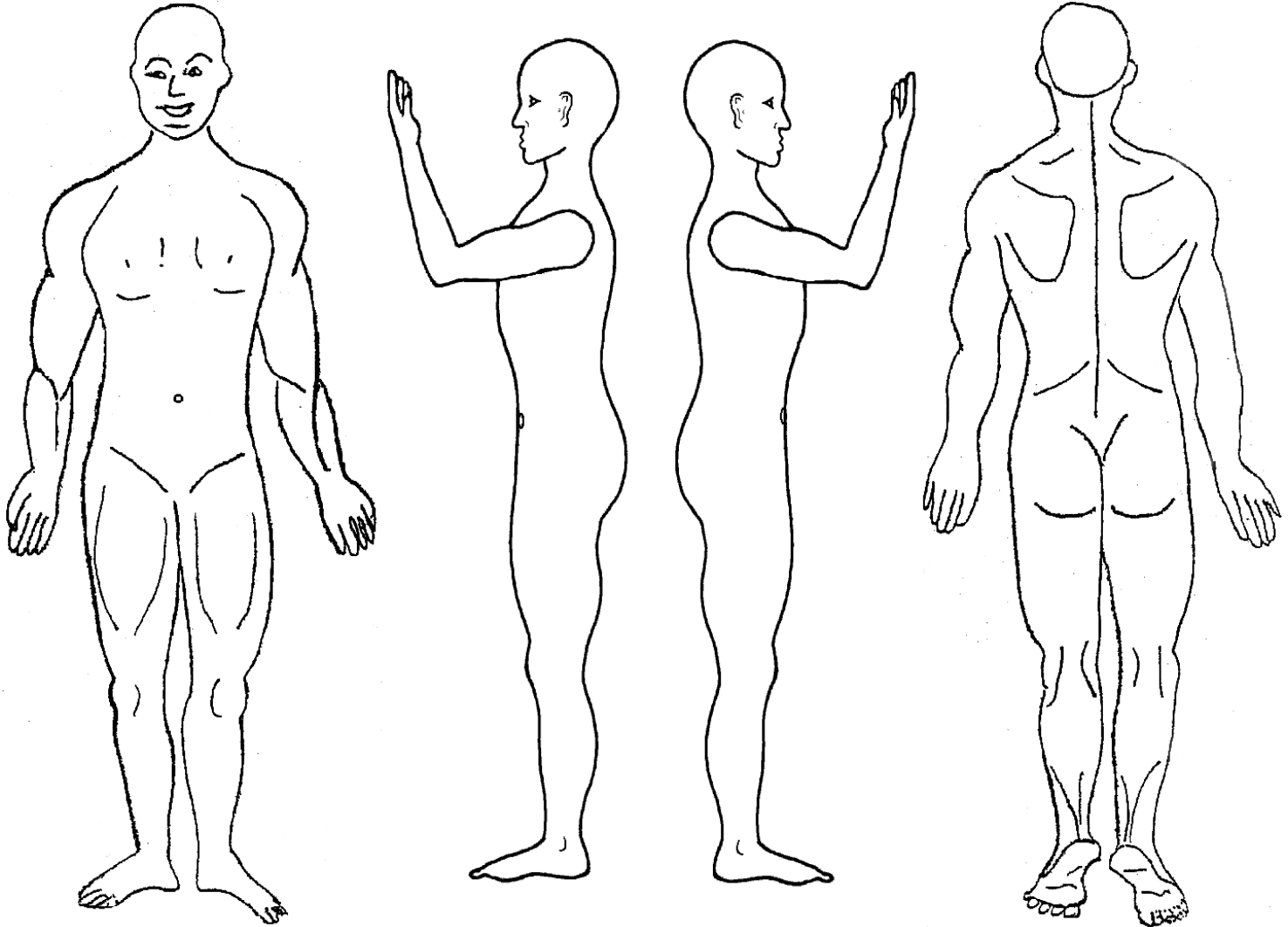
**Food Stressors** Please indicate how many times per week you consume the following foods:

Stimulants	Toxic Oils	Commercial Dairy	Highly Heated Foods
Coffee <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>

# 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 as 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.")