



ON-GOING 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: _____ Date of Previous Nutritional Program _____

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, including any new problems or injuries since your last evaluation. Please include what's better, too!

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. **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? _____

6. **Stress Level** 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? _____

7. **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 _____

Do you have dental work currently in progress? _____ Name of Dentist: _____

Do you need further dental work? _____ If so, what? _____

8. New Stress Do you have any new physical stresses since your last program:

Breast implants? _____ Other surgical implants? _____ Tattoos? _____ Electric surgery (*liposuction, face-lift removed moles, near-sightedness laser surgery, etc.*)? _____ Metal or plastic placed inside your body (*ear or body piercings, pins, clamps, etc.*)? _____

Health Overview

For the following questions, circle the phrases that apply to you.

1. **Sleep** How is your sleep? _____
What time do you usually go to sleep? _____ Number of hours of sleep per night? _____

2. **Digestion** How is your digestion? _____

3. **Urination** How are your daily urinations? _____

4. **Bowels** How are your bowel eliminations? _____

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? _____)
How are your monthly periods? _____

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*)? _____
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)? _____

Which electromagnetic devices do you have? Computer Circuit Television DC Protector Phone Cell Phone Auto

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 VitaMix 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, non-stick Illumina, non-stick T-Fal.]
 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)? _____

Nutritional Progress

1. Please rate how well you were able to take your recommended nutritional supplements (on a scale of 1 to 10, 10 being perfect): _____
 Did you have any difficulties? _____ If so, what? _____

2. Please rate how well you were able to follow the recommended dietary and lifestyle suggestions (on a scale of 1 to 10, 10 being perfect): _____
 Did you have any difficulties? _____ If so, what? _____

Food Choices

Circle each type of food you eat often:

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 farmer)
7. **Fresh fruit:** a) commercially grown (store-bought) c) organically grown (store-bought) c) organically grown (direct from farmer)
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) naturally grown eggs c) commercial butter d) natural 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 cheese (store-bought) c) recommended aged cheeses (see list)
13. **Condiments:** a) commercial salt and/or pepper b) pink sea salt (PRL) c) artificial sweeteners (Equal, Sweet 'N Low, Coffeemate, etc.)
 d) commercial ketchup or mustard e) commercial vinegar f) commercial olive oil g) PRL Olive Oil

Food Stressors

Circle which of the following you have every week. In the column, indicate how many times per week you have each item.

Stimulants	Toxic Oils	Commercial Dairy	Highly Heated Foods
Coffee (including decaf.)	Fried foods	Cow's Milk (store bought)	Bread (store-bought)
Black tea, caffeine drinks	Fast food	Yogurt (store bought)	Crackers (store-bought)
Soft drinks (colas, etc.)	Potato or corn chips	Ice cream (store bought)	Bagels (store-bought)
Drinks with NutraSweet	Roasted nuts	Cottage cheese (store)	Buns (store-bought)
Alcohol (wine, beer, etc.)	Mayonnaise	Sour cream (store bought)	Pasta (store-bought)
Chocolate (commercial)	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: _____)

