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)*	

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? _____

Personal Health Goals

1. Do you want to lose weight?_____ If so, how much?_____

2. How important is your health to you, on a scale from 1 – 10 (1 = lowest; 10 = the highest importance)?
_____

3. How much confidence do you have in medical drugs, on a scale from 1- 10 (1 = low; 10 = high confidence)? _____

4. How much confidence do you have in your body's ability to heal itself (if given the right nutrients/natural therapies), on a scale from 1 to 10 (1 = low; 10 = high confidence)? _____

5. List any nutritional supplements that you regularly take: _____

_____

6. What best describes your diet overall (**please be honest**)? Check all that apply:

__ mostly eat out (fast food)
__ mostly eat out (but try to eat healthier items)
__ eat whatever is available
__ occasional binges
__ would never give up meat
__ eat a lot of fresh food (very little from cans, boxes)
__ mostly homemade meals
__ vegetarian
__ eat mostly organic
__ eat a lot of raw food
__ in transition to eating better

7. What are your specific health goals? (What do you *really* want?) _____

_____

8. How far are you willing to commit to achieve your health goals? (**Please be honest.**)

__ don't really want to change much
__ willing to change some
__ willing to change a reasonable amount
__ willing to do whatever it takes

9. How much money do you spend per month on your health, out of pocket? _____

10. How long do you want to live? (Check all that apply.)

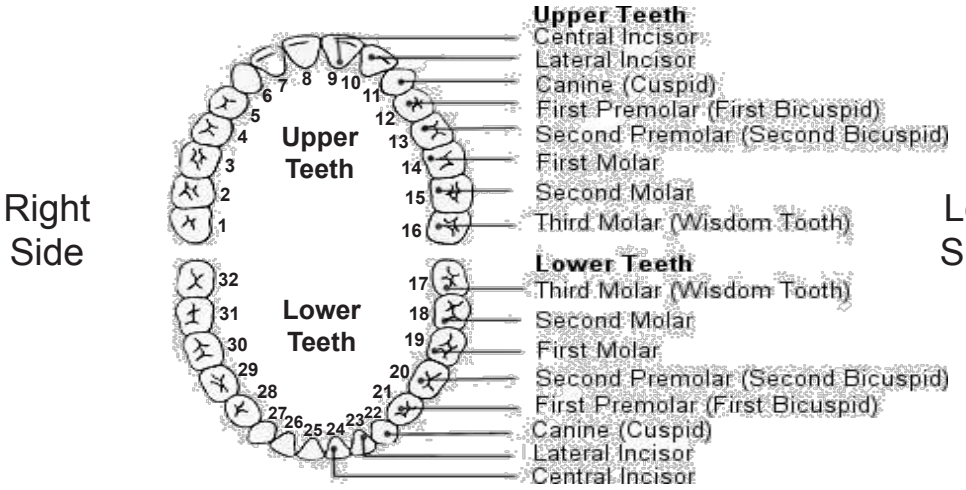
__ age 60-70
__ age 70-80
__ age 80-90
__ age 90 - 100
__ age 100+

__ as long as I'm healthy
__ as long as I have been granted
__ until I complete my mission (purpose) on earth
__ only if my significant other is still alive also
__ forever
__ it's already enough

Dental History Chart

Name: _____ Date: _____

Tooth Reference Chart

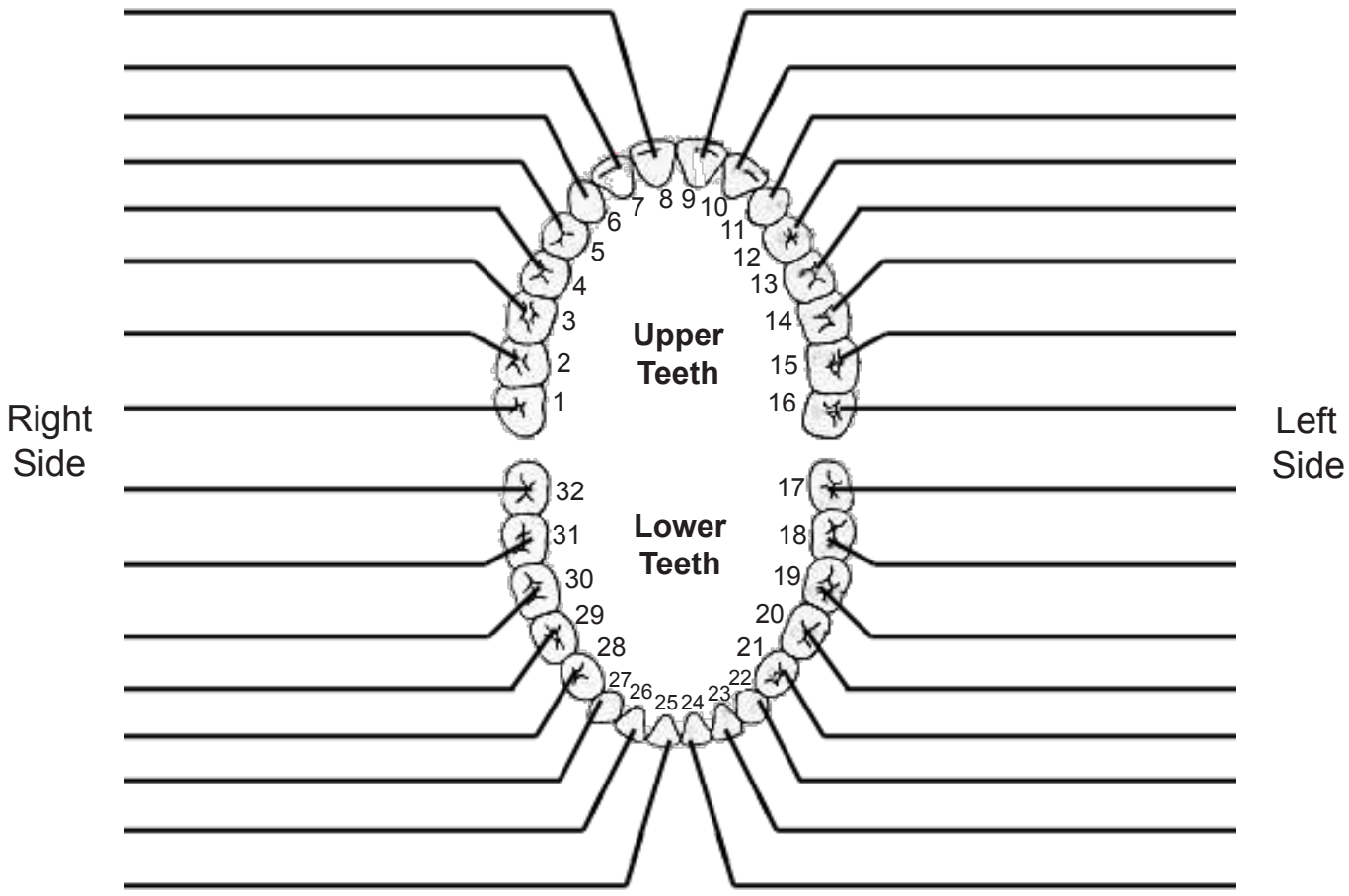


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example Chart on back.**

Please use the following descriptors when filling in the chart:

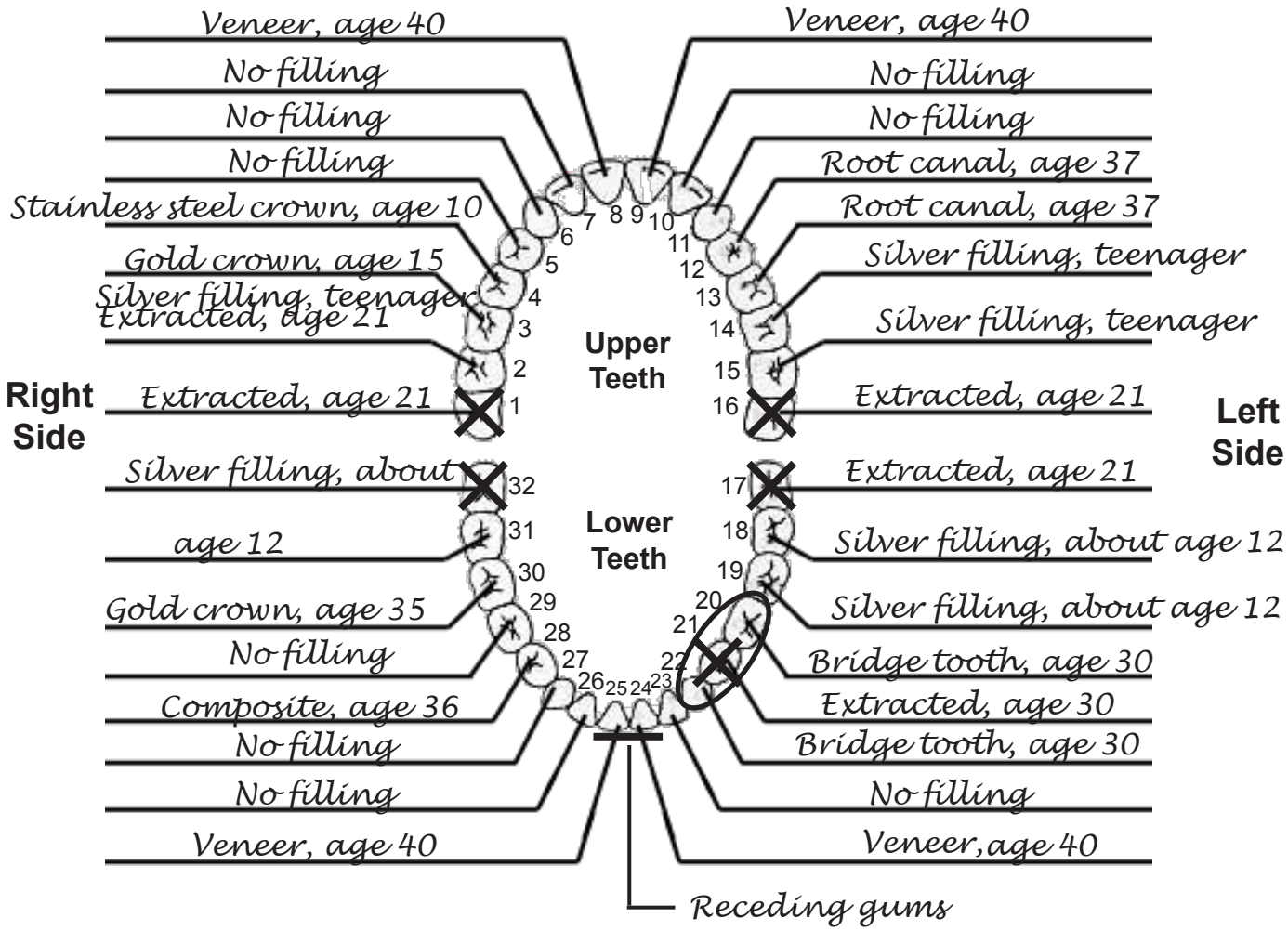
- Silver filling
- Composite filling *(plastic-like filling)*
- Gold crown
- Stainless steel crown
- Root canal
- Post (in root canal)
- Veneers
- Bridge *(circle teeth with bridge attached)*
- Partial denture
- Full denture
- Extracted tooth *(write next to X'd out tooth)*
- No filling

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.



Example Dental Chart

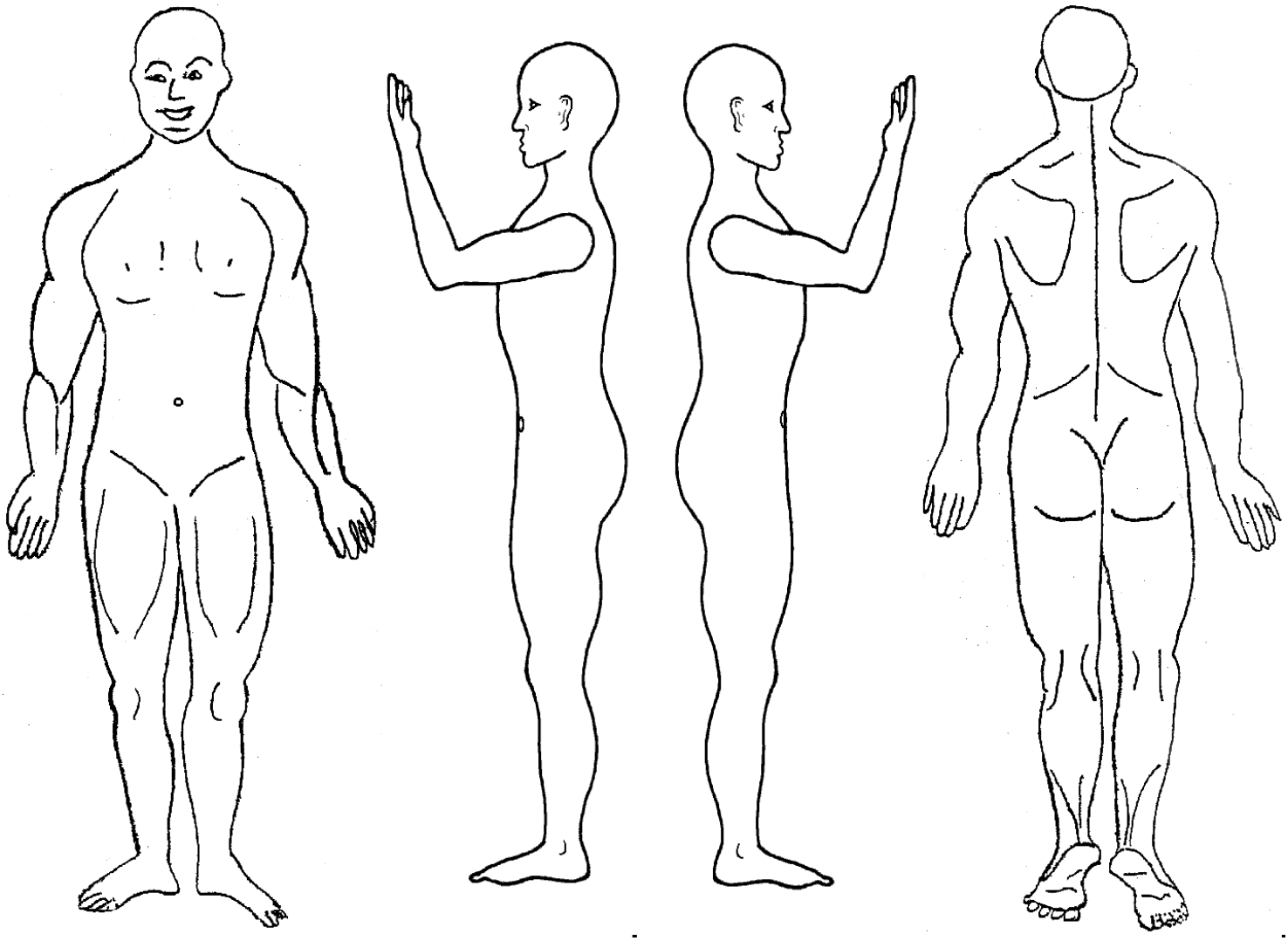
Name: _Den Tall_____ **Date:** _4-10-07_



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.")

Rev. 07-18-07

The Three Body Types

Identifying Your Constitution

To learn your basic Ayurvedic constitution type (called a "dosha"), please rate the following traits as they have pertained to you in the last 2 to 3 years.

Answer each number and be sure to put a number in all 3 blanks per line, even if it is "0".

0 = Doesn't describe me at all
1 = Describes me a little
2 = Describes me quite well
3 = Describes me almost perfectly

	VATA	PITTA	KAPHA
1. My hair texture tends to be:	____ Dry, curly wavy, shiny	____ Straight or fine	____ Thick or full bodied
2. My hair color is:	____ Medium or or light brown	____ Blond or reddish tone or early gray	____ Dark brown or black
3. My skin tends to be:	____ On the dry side	____ Delicate or sensitive	____ Oily or smooth
4. My complexion (when compared with others of my race) is:	____ Darker	____ More reddish or freckled	____ Lighter
5. Compared with others of my height, I have:	____ Smaller bones	____ Average-size bones	____ Larger bones
6. My weight is:	____ Thin; I don't gain weight	____ Average	____ Heavy
7. My energy level:	____ Tends to fluctuate, may be high or low	____ Is moderate to high; I can push myself too hard	____ Is steady
8. Regarding temperature, I:	____ Dislike cold; am comfortable in heat	____ Dislike heat, perspire easily, like cool temperatures	____ Dislike damp and cold, can tolerate extremes well
9. My typical hunger level:	____ Can vary from excessive to no interest in food	____ Is intense; I need regular meals	____ Is usually low but can be emotionally driven
10. I prefer my food/drinks:	____ Warm or moist or oily	____ Cold	____ Warm or dry
11. I generally eat:	____ Quickly	____ Moderately fast	____ Slowly
12. My sleep is most often:	____ Interrupted, light	____ Sound, moderate	____ Deep, long
13. My sexual interest is:	____ Strong when romantically involved; low to moderate otherwise	____ Moderate to strong	____ Slow to awaken but then is sustained
14. My emotional moods:	____ Change easily; I'm very responsive	____ Are intense; I'm quick-tempered	____ Are even; I'm slow to anger
15. My general reaction to stress is:	____ Anxious, fearful	____ Irritated	____ Mostly calm
16. With regard to money, I:	____ Am easy and impulsive	____ Am careful, but I spend	____ Tend to save, accumulate
SUBTOTALS:	**VATA = _____**	**PITTA = _____**	**KAPHA = _____**

	VATA	PITTA	KAPHA
17. My way of learning is:	____ To learn quickly, enjoy more than one thing at a time	____ To focus sharply, discriminate	____ To take my time
18. With regard to tasks, I may:	____ Start a task, but not finish	____ Finish what I start	____ Tend to be methodical
19. My memory is:	____ Best in the short term	____ Good overall	____ Best in the long term
20. My way of speaking is:	____ Quick, often imaginative or excessive	____ Clear, precise detailed, well-organized	____ Soothing, calm
21. If there was one trait to best describe me, it would be:	____ Vivacious	____ Determined	____ Easygoing
22. Regarding my relationships, I:	____ Easily adapt to different kinds	____ Often choose friends on the basis of their values	____ Am slow to make new friends, but then I am loyal
23. My family and friends might prefer me to be more:	____ Settled	____ Tolerant	____ Enthusiastic

SUBTOTALS: **VATA = _____** **PITTA = _____** **KAPHA = _____**

Add each of the subtotals together for each dosha, then enter in the grand total for each one.

GRAND TOTAL **VATA = _____** **PITTA = _____** **KAPHA = _____**

0 = Doesn't describe me at all
1 = Describes me a little
2 = Describes me quite well
3 = Describes me almost perfectly

ASSESSING YOUR SCORE

If one column total is 15 or more points higher than the other two column totals, this is clearly your dominant constitutional type -- vata, pitta or kapha.

If two of the column totals are 0 to 15 points apart, you are a dual-dosha constitutional type -- vata-pitta (or pitta-vata), pitta-kapha (or kapha-pitta), or vata-kapha (or kapha-vata).

If all three column totals are within 0 to 10 points of each other, you are a tri-dosha constitutional type (the most balanced type).

Birth Dosha: To determine your original constitutional type, take this test again, only answer the questions as they would have pertained to you as a child. Compare your present (acquired dosha) with your birth dosha.

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