HEALTH EVALUATION

Name: ______________________________________ Date: ________________

Address: ____________________________________ City _______________ St_____ Zip _________

Home Phone: _______________________ Cell __________________ Email: _____________________

Referred by: _________________________________ Age: _________ Birth Date: ___________

Male/Female: _______________ Height: __________ Weight: _____________

Goals/Areas of concern regarding your health: ____
____
____
____

PRESCRIPTION DRUG USAGE - Please check the box if you use any of the following:

A. □ Antacids, Zantac, Pepcid AZ, Rolaids, etc
□ Chemotherapy

B. □ Laxatives
□ Ulcer medications
□ Antibiotic / Antifungal

C. □ Anti-diabetic / Insulin

D. □ Oral Contraceptives

E. □ Hormones

F. □ Relaxants / Sleeping Pills
□ Thyroid
□ Radiation
□ Antidepressants

G. □ Aspirin / Acetaminophen
□ Cortisone / Anti-Inflammatory
□ Heart Medications
□ High Blood Pressure Medicine

Are you currently taking any supplements: ____
____

DIETARY HABITS: Describe the foods you normally eat:

BREAKFAST: ____

LUNCH: ____

DINNER: ____

SNACKS: ____

BINGE: ____

Please Circle YES or NO

Do you consume:

Question		
1. Soda or carbonated beverages of any kind including carbonated water?	YES	NO
2. White flour products?	YES	NO
3. Fried foods?	YES	NO
4. Fast foods regularly?	YES	NO
5. Fifty percent of your food in its raw form?	YES	NO
6. Sugars other than fructose, sucanat (sugar cane), Stevia, or raw organic honey?	YES	NO
7. Artificial sweeteners?	YES	NO
8. Candy?	YES	NO
9. Red meat or pork?	YES	NO
10. Tap water? If no, what type of water ________________________	YES	NO
11. Eight to ten glasses of water daily?	YES	NO
12. Coffee?	YES	NO
13. Alcoholic beverages?	YES	NO
14. Artificial colors, flavoring, MSG or preservatives (BHT, etc)?	YES	NO
15. Hydrogenated or partially hydrogenated oils?	YES	NO
16. Any tobacco products?	YES	NO
17. Real butter as opposed to margarine?	YES	NO
18. Oils in the form of extra virgin olive oil and safflower or canola oil daily?	YES	NO
19. One Tbsp. of flax seeds daily?	YES	NO
20. Are you a vegetarian?	YES	NO
21. At least 6 servings of whole grains daily? (Serving size: 1 piece of bread)	YES	NO
22. At least 3 servings of fresh fruit daily?	YES	NO
23. At least 3 servings of fresh vegetables daily?	YES	NO
24. Two to three servings of protein daily (eggs, raw nuts, legumes, beans, lean meat)?	YES	NO
25. Two servings daily of dairy (low-fat milk, cottage cheese, yogurt, etc)?	YES	NO
26. Mainly grains, some fruits & vegetables, a small amount of dairy and protein and minimal fats, oils and sweets daily?	YES	NO
27. Are you currently involved in an aerobic exercise program? If yes, how many days/week? _________	YES	NO
28. Are you currently involved in a strength-training program? If yes, how many days/week? _________	YES	NO
29. Prescription Drug Abuse?	YES	NO
30. Recent change in appetite?	YES	NO
31. Do you use food to relieve stress or “self-medicate”?	YES	NO
32. Do you eat everything on your plate, even if you are full?	YES	NO
33. Have you ever been diagnosed with an eating disorder?	YES	NO

List anything else that would help us understand your diet and lifestyle:

[Type text]

INSTRUCTIONS: Circle the best answer that describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank. Repeated questions should be answered as they appear.

N-0 = NO **Y-2 = YES** **S-1 = SOMETIMES**

**Total each section when you complete the evaluation*

Question	N	Y	S	
Section 1				
Do you experience bloating?	N-O	Y-2	S-1	
Fullness for extended time after meals?	N-O	Y-2	S-1	
Sleepy or low energy after eating?	N-O	Y-2	S-1	
Do you experience indigestion or take antacids?	N-O	Y-2	S-1	
Uncomfortable/adverse reactions to food?	N-O	Y-2	S-1	
Total Score:_______________				
Section 2				
Do you have varicose veins/bruise easily?	N-O	Y-2	S-1	
Do you have poor stamina?	N-O	Y-2	S-1	
Do you have persistent leg cramps?	N-O	Y-2	S-1	
Are you nervous/have poor concentration?	N-O	Y-2	S-1	
Is your vision failing rapidly?	N-O	Y-2	S-1	
Total Score:_______________				
Section 3				
Do you have dry skin?	N-O	Y-2	S-1	
Do you experience grinding in your joints?	N-O	Y-2	S-1	
Days without eating avocados, raw nuts flax seeds(oil), etc?	N-O	Y-2	S-1	
Do you suffer from learning disabilities or poor concentration?	N-O	Y-2	S-1	
Are you overweight?	N-O	Y-2	S-1	
Total Score:_______________				
Section 4				
Do you crave sweets & sugars?	N-O	Y-2	S-1	
Do you feel weak/faint between meals?	N-O	Y-2	S-1	
Is your triglyceride level over 175?	N-O	Y-2	S-1	
Are you unable to lose or gain weight?	N-O	Y-2	S-1	
Family history of diabetes?	N-O	Y-2	S-1	
Total Score:_______________				
Section 5				
Are you a Diabetic?	N-O	Y-2		
Does your diet consist of processed sugars or starches such as white flour, white--bread & pastas ?	N-O	Y-2	S-1	
Are you Hyperglycemic?	N-O	Y-2		
Do you experience poor circulation?	N-O	Y-2	S-1	
Total Score:_______________				

Questionnaire	
Section 6 Do you struggle with Portion-Control? N-O Y-2 S-1 Do you find it hard to lose weight? N-O Y-2 S-1 Is Belly Fat a concern? N-O Y-2 S-1 Do you consume processed fats? N-O Y-2 S-1 Total Score:_______________	
Section 7 Have you been on a high-protein diet or eat more than 6 oz or protein a day? N-O Y-2 S-1 Are your injuries slow to heal? N-O Y-2 S-1 Do you have frequent fevers or infections? N-O Y-2 S-1 Do you have muscle cramps or pain? N-O Y-2 S-1 Have you been injured within last 3 months? N-O Y-2 S-1 Do you experience poor circulation? N-O Y-2 S-1 Total Score:_______________	
Section 8 Do you work out? N-O Y-2 S-1 Do you find it hard to gain muscle? N-O Y-2 S-1 Do you find it hard to maintain muscle? N-O Y-2 S-1 Are you recovering from surgery/injury? N-O Y-2 S-1 Do you have a long term digestive issue? N-O Y-2 S-1 Do you have problems maintaining the proper PH balance in your body? N-O Y-2 S-1 Total Score:_______________	
Section 9 Do you have chronic pain? N-O Y-2 S-1 Do you have bursitis? N-O Y-2 S-1 History of joint injury? N-O Y-2 S-1 Do you have swollen joints/arthritis? N-O Y-2 S-1 Do you have increased flexibility in your joints (double-jointed)? N-O Y-2 S-1 Total Score:_______________	
Section 10 Are the whites of your eyes yellowish? N-O Y-2 S-1 Do you experience back pain over kidneys? N-O Y-2 S-1 Do you have strong-smelling urine? N-O Y-2 S-1 Do you take anti-inflammatory drugs? N-O Y-2 S-1 Do you have age spots? N-O Y-2 S-1 Total Score:_______________	
Section 11 Do you have anemia? N-O Y-2 S-1 Is your skin clammy? N-O Y-2 S-1 Do you have frequent headaches? N-O Y-2 S-1 Do you experience low energy or fatigue? N-O Y-2 S-1 Do you exercise over 6 hours a week? N-O Y-2 S-1 Total Score:_______________	

Section 12				
Do you consume dairy products, meat and/or poultry?	N-O	Y-2	S-1	
Are you taking or have taken antibiotics within the last 90 days?	N-O	Y-2	S-1	
Do you have a history of food poisoning?	N-O	Y-2	S-1	
Traveled overseas in last 3 months?	N-O	Y-2	S-1	
Do you have persistent gas?	N-O	Y-2	S-1	
Total Score:________________				
Section 13				
Have you had any hormonal problems?	N-O	Y-2	S-1	
Do you have osteoporosis?	N-O	Y-2	S-1	
Days without eating raw leafy green vegetables?	N-O	Y-2	S-1	
Are you over 50?	N-O	Y-2	S-1	
Do you have a small frame or low weight?	N-O	Y-2	S-1	
Total Score:_______________				
Section 14 --Males Only				
Does your bladder always feel full?	N-O	Y-2	S-1	
Do you experience inconsistent pressure or pain during urination?	N-O	Y-2	S-1	
Does ejaculation cause pain?	N-O	Y-2	S-1	
Do you experience low sex drive?	N-O	Y-2	S-1	
Do you have premature ejaculation?	N-O	Y-2	S-1	
Total Score:_______________				
Section 15 – Females Only				
Do you experience depression, moodiness/irritability?	N-O	Y-2	S-1	
Do you have heavy menstrual bleeding?	N-O	Y-2	S-1	
Do you have monthly cramps?	N-O	Y-2	S-1	
Do you have tender breasts?	N-O	Y-2	S-1	
Are you postmenopausal?	N-O	Y-2	S-1	
Total Score:_______________				
Section 16				
Are you ever constipated?	N-O	Y-2	S-1	
Do you ever experience diarrhea?	N-O	Y-2	S-1	
Do you take laxatives?	N-O	Y-2	S-1	
Day or days without a bowel movement?	N-O	Y-2	S-1	
Have you been exposed to metal toxicity?	N-O	Y-2	S-1	
Total Score:_______________				
Section 17				
Do you experience tiredness during day?	N-O	Y-2	S-1	
Do you experience loss of mental clarity?	N-O	Y-2	S-1	
Do you find it difficult to make decisions?	N-O	Y-2	S-1	
Total Score:_______________				

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Section 18

Do you experience bleeding gums? N-O Y-2 S-1
Do you experience frequent colds or flu like symptoms? N-O Y-2 S-1
Days without fresh fruit? N-O Y-2 S-1
Do you currently take a synthetic Vitamin C supplement (ex. As ascorbic acid)? N-O Y-2 S-1
Do you or have you had cancer? N-O Y-2 S-1

Total Score:_______________

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Section 19

Do you experience light headedness when standing up? N-O Y-2 S-1
Do you rely on coffee, tea or soda to make it through the day? N-O Y-2 S-1
Do you experience high stress levels? N-O Y-2 S-1
Are you an adrenaline junkie? N-O Y-2 S-1
Is it difficult for you to maintain or gain weight?? N-O Y-2 S-1

Total Score:_______________

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Section 20

Do you have prolonged exposure to sun? N-O Y-2 S-1
Do you consume alcohol? N-O Y-2 S-1
Are you exposed to toxic substances? (fumes, chemicals, smoke, etc) N-O Y-2 S-1
Are you currently being treated with medications? N-O Y-2 S-1
Do you partake in strenuous activities for more than 1 hour at a time? N-O Y-2 S-1

Total Score:_______________

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Section 21

Do you eat a lot of processed fatty foods? N-O Y-2 S-1
Eat more than 3oz servings of protein daily? N-O Y-2 S-1
When you grab your wrist, does your finger and thumb easily touch? N-O Y-2 S-1
Do you salt your foods? N-O Y-2 S-1
Drink caffeinated drinks (coffee, soda, tea)? N-O Y-2 S-1

Total Score:

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Section 22

Exposed to pesticides, paint or hair chemicals? N-O Y-2 S-1
Family history of cancer? N-O Y-2 S-1
Do you bruise easily? N-O Y-2 S-1
Are you sensitive to chemicals or environmental pollution? N-O Y-2 S-1
Do you have vision problems? N-O Y-2 S-1

Total Score:_______________

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Section 23

Do you work out on a regular basis? N-O Y-2 S-1
Looking for healthy protein sources? N-O Y-2 S-1
Are you an extreme athlete? N-O Y-2 S-1

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