



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? _____
Do you frequently breathe the smoke from others who are smoking (either at work or at home)? _____

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>

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?) _____

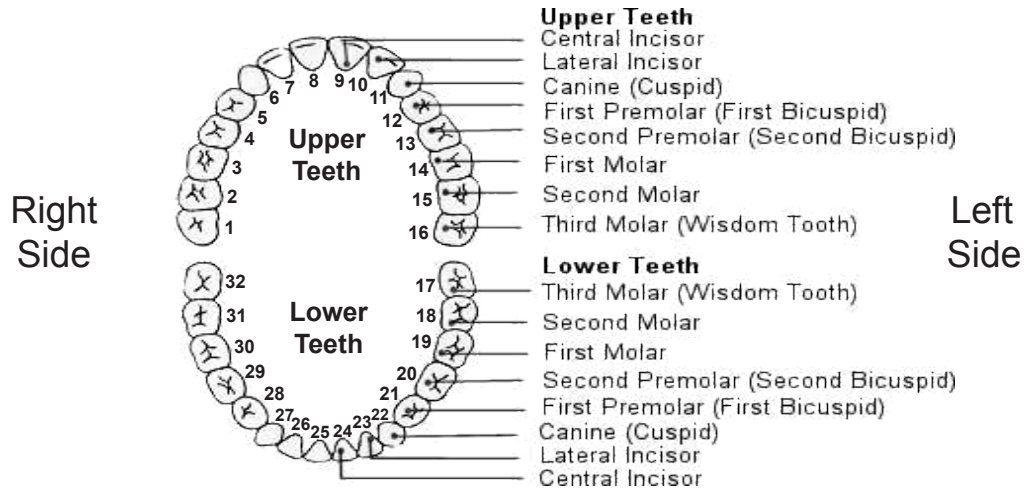
8. How far are you willing to commit to achieve your health goals? (**Please be honest.**)
 - don't really want to change much
 - willing to change some
 - willing to change a reasonable amount
 - willing to do whatever it takes
9. How much money do you spend per month on your health, out of pocket? _____
10. How long do you want to live? (Check all that apply.)

<input type="checkbox"/> age 60-70	<input type="checkbox"/> as long as I'm healthy
<input type="checkbox"/> age 70-80	<input type="checkbox"/> as long as I have been granted
<input type="checkbox"/> age 80-90	<input type="checkbox"/> until I complete my mission (purpose) on earth
<input type="checkbox"/> age 90 - 100	<input type="checkbox"/> only if my significant other is still alive also
<input type="checkbox"/> age 100+	<input type="checkbox"/> forever
	<input type="checkbox"/> it's already enough

Dental History Chart

Name: _____ Date: _____

Tooth Reference Chart

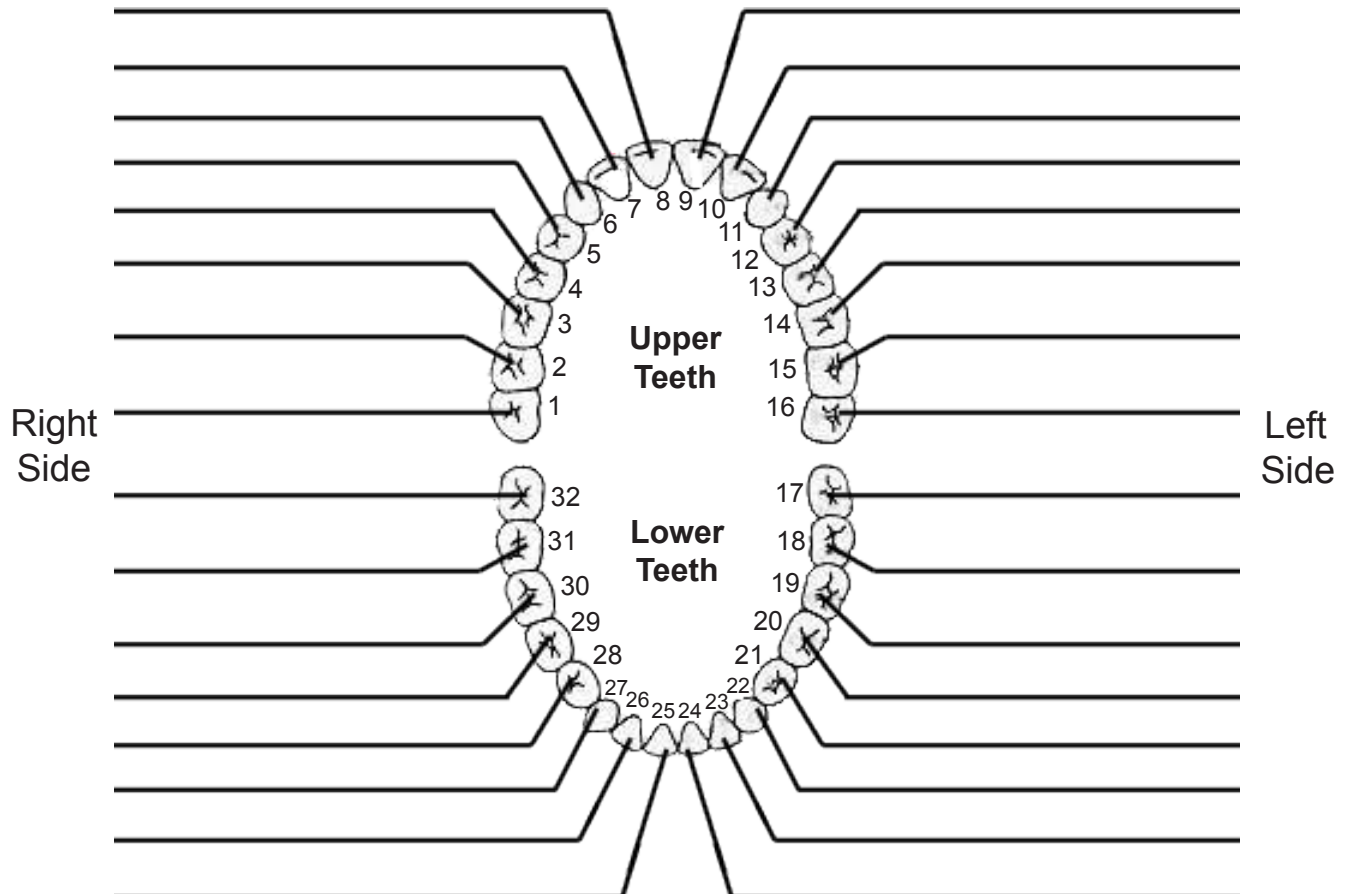


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example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

Please use the following descriptors when filling in the chart:

- | | | | |
|---------------------------------------------------|-----------------------|-----------------------------------------------------|--------------------------------------------------------|
| Silver filling | Stainless steel crown | Bridge (<i>circle teeth with bridge attached</i>) | Full denture |
| Composite filling (<i>plastic-like filling</i>) | Root canal | Partial denture | Extracted tooth (<i>write next to X'd out tooth</i>) |
| Gold crown | Veneers | | No filling |

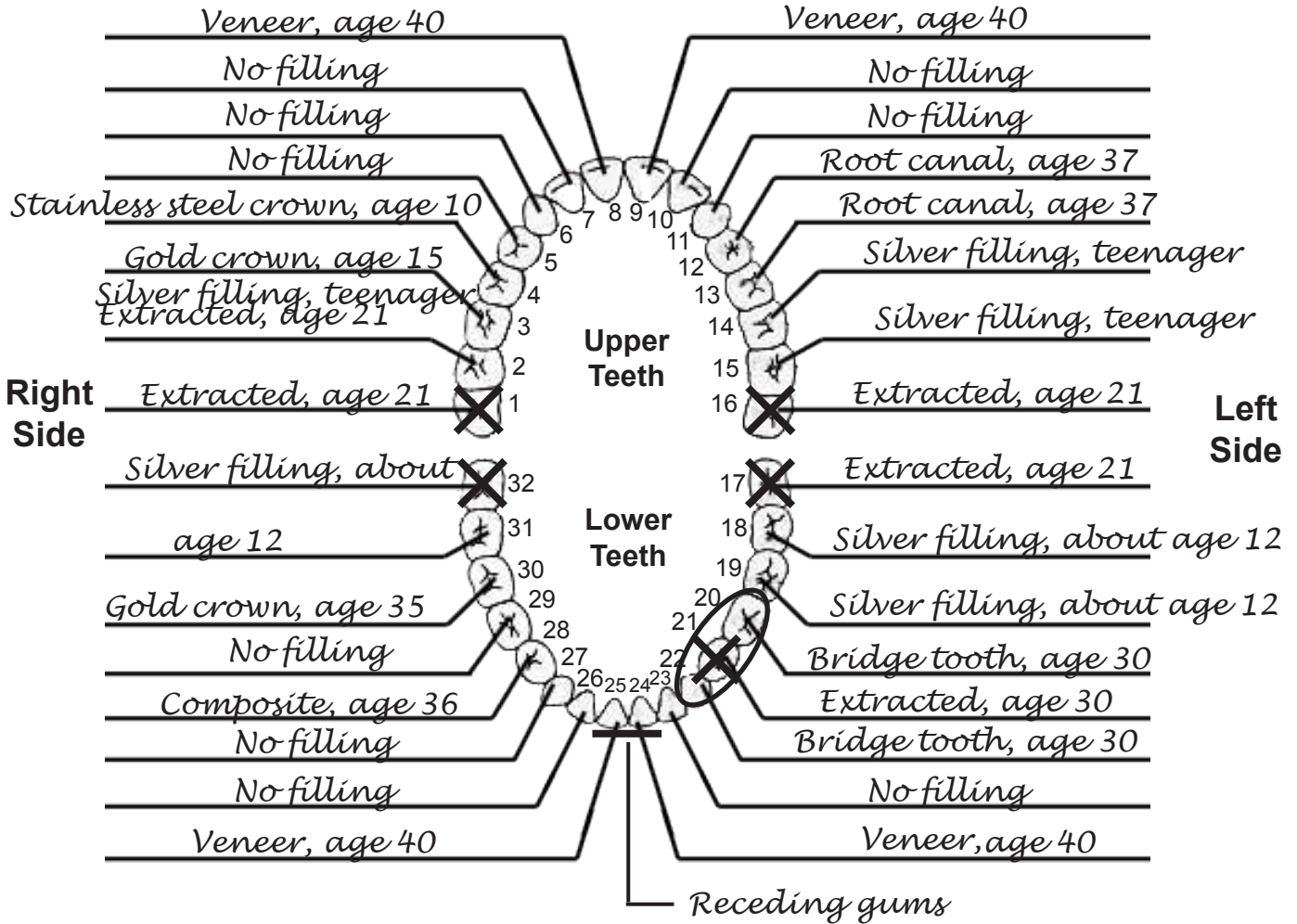
Gum Concerns: please make a line at the base of any teeth that have gum problems and indicate what type of concern, such as deep pockets, receding gums, bleeding gums, etc.



Example Dental Chart

Name: Den Tall

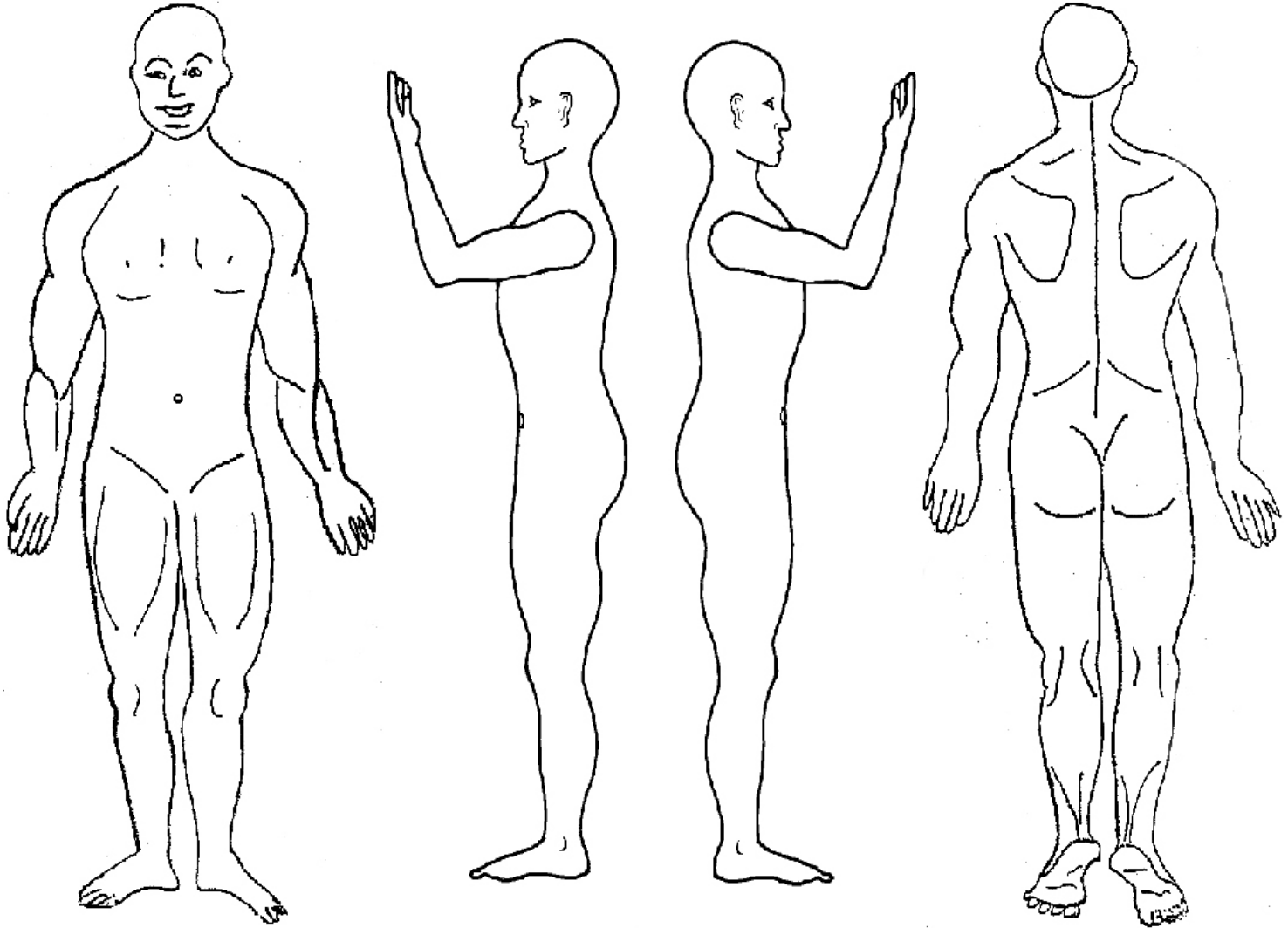
Date: 4-10-07



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 (no matter how long ago), 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.")

Examples of Common Interference Fields

Scars

C-Section Scar

Swollen Legs

86-Year-Old Woman

C-section scar (from 55 years ago) blocking 8 different meridians, reflexing downwards to cause stiff, swollen legs

Neck Stiffness

Vaccination Scar

30-Year-Old Businessman

Vaccination scar (from 20 years ago) blocking outflow of head and neck meridians, creating stiff neck

Episiotomy Scar

Sciatica Pain

42-Year-Old Housewife

Episiotomy scar (from 15 years ago) reflexing to left leg creating sciatica pain

Traumatized Areas

Whiplash

Liver Sedation

18-Year-Old Student

Weak neck area from previous car accident (5 years ago) reflexing to liver area to create allergic reactions

Abdominal Weight Gain

Fall on Hip (15 years ago)

55-Year-Old Sales Director

Weak area from previous fall on hip area (15 years ago) reflexing to abdominal area creating excess abdominal weight

Heart Palpitations

Ankle Sprain (10 years ago)

45-Year-Old Journalist

Weak area due to ankle sprain (10 years ago) reflexing to heart area, creating heart palpitations

Abnormal Body Areas

Weight Gain

Leg Bruise

58-Year-Old Female Caretaker

Bruise on left leg area after a fall (1 year ago) still there, reflexing to abdominal area creating weight gain

Excess Weight

Toenail Fungus

67-Year-Old Male CEO

Toe nail fungus on both feet (over 30 years) reflexing to stomach area to create excess stomach weight

Insomnia

3rd Molar Decay

Jittery Feeling

27-Year-Old Male Mechanic

Decaying 3rd molar reflexing to chest to create a jittery feeling that then creates insomnia at night

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 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
SUBTOTALS:	VATA = _____	PITTA = _____	KAPHA = _____

	VATA	PITTA	KAPHA
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-pita (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.