



HealthLine

2000 N. Mays, #126
Round Rock, TX 78664

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.) Do you have breast implants? _____ Other surgical implants or prostheses? _____
- b.) Have you had elective surgery (tummy tuck, face-lift, burned off moles, etc.)? _____
- c.) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)? _____
- d.) 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 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 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? _____
Type of mattress? _____ Type of pillow, sheets, covers, bedding? _____
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? _____)

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)? _____
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 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)? _____

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*)
 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) biogenic (*from PR Labs*)
9. **Whole beans:** a) commercially grown (*store-bought*) b) organic (*store-bought*) c) biogenic (*from PR Labs*)
10. **Eggs/ Butter:** a) commercial eggs (*store-bought*) b) naturally grown eggs c) commercial butter d) natural butter
11. **Milk:** a) commercial milk b) Alta Dena milk c) goat's milk d) Claravale raw milk
12. **Cheese:** a) commercial cheese b) organic cheese (*store-bought*) c) biogenic cheese (*Elby Feta cheese, Bulgarian cheese, Danish blue*)
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) vinegar f) commercial olive oil g) PRL Moroccan 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 (<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

- Eating Out** Do you eat out at restaurants? _____ If yes, how often? _____ Where? _____
What type of food do you eat at restaurants? _____
- Home Meals** Do you prepare meals at home? _____ If so, how often? _____
If yes, what type of food do you prepare? _____
- Meal Habits** Do You: [circle] a) skip meals often b) have irregular eating times c) eat food past 7 PM
- MSG** Do you avoid food/drinks that list “natural flavors” (which means hidden MSG) on the label? _____
- 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 Moroccan Olive Oil.”) PLEASE, BE HONEST!

BREAKFAST: (Time eaten: _____)

LUNCH (Time eaten: _____)

DINNER (Time eaten: _____)

SNACKS (Time eaten: _____)
