First Time Evaluation
International Nutraceuticals

Please complete the following questions carefully. This information will help.

Today's Date:_____ Referred By:_____

Name:_____ Birthday:_____

Mailing Adress:_____

City:_____ State:_____ Zip:_____

Occupation:_____

Height:_____ Weight:_____ Email:_____

No. of Children:_____ Phone #s:_____

Do Not Take Any Supplements for 2 Meals before Evaluation

1. Complaints: Please rate current complaints from 1-10 (10 being most severe).

_____

_____

2. Other information: additional information or concerns about your health.

_____

_____

3. Medications: Please list any medication you are currently taking and how long you have been on them.

_____

_____

4. Smoking: Do you currently smoke?_____ If so, how much?_____

Do you frequently breathe smoke from others smoking?_____

5. Surgeries: What surgeries, operations, traumas, car accidents, etc., have you had?

6. Scars: Describe any and all scars on your body – major and minor.

7. Drugs: This is confidential information. Do you currently use recreational drugs?

Describe usage:_____

Have you used recreational drugs in the past? If so, please describe._____

8. Stress: Please rate your current stress level from 1-10 (10 being the highest)._____

9. Dental work: Indicate how many of the following you have:

Silver Fillings_____	Gold crowns or inlays_____	Root canals_____	Braces_____
Composites_____	Stainless steel crowns or inlays_____	Root canals w/ Unocal_____	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_____

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 2-3 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 mucous, 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 the 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 a night 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)?_____