

Think Healthy. Feel Healthy. Live Healthy.
Transformation

www.transformation-nc.com

919-845-6596

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: (____) _____

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 and/or supplements 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 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 ____
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, Ultrex] 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 (such as Claravale)

12. Cheese: a) commercial cheese b) organic aged cheese *(store-bought)* c) aged cheeses

13. Other: A) commercial ketchup, mustard, spices b) commercial vinegar c) commercial olive oil

Please indicate how many times per week you consume the following 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 Artificial Sweeteners ___ 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) Don't eat 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 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/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? _____
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? _____