Transformation
Think Healthy, Feel Healthy, Live Healthy.

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 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?
_____
_____
_____

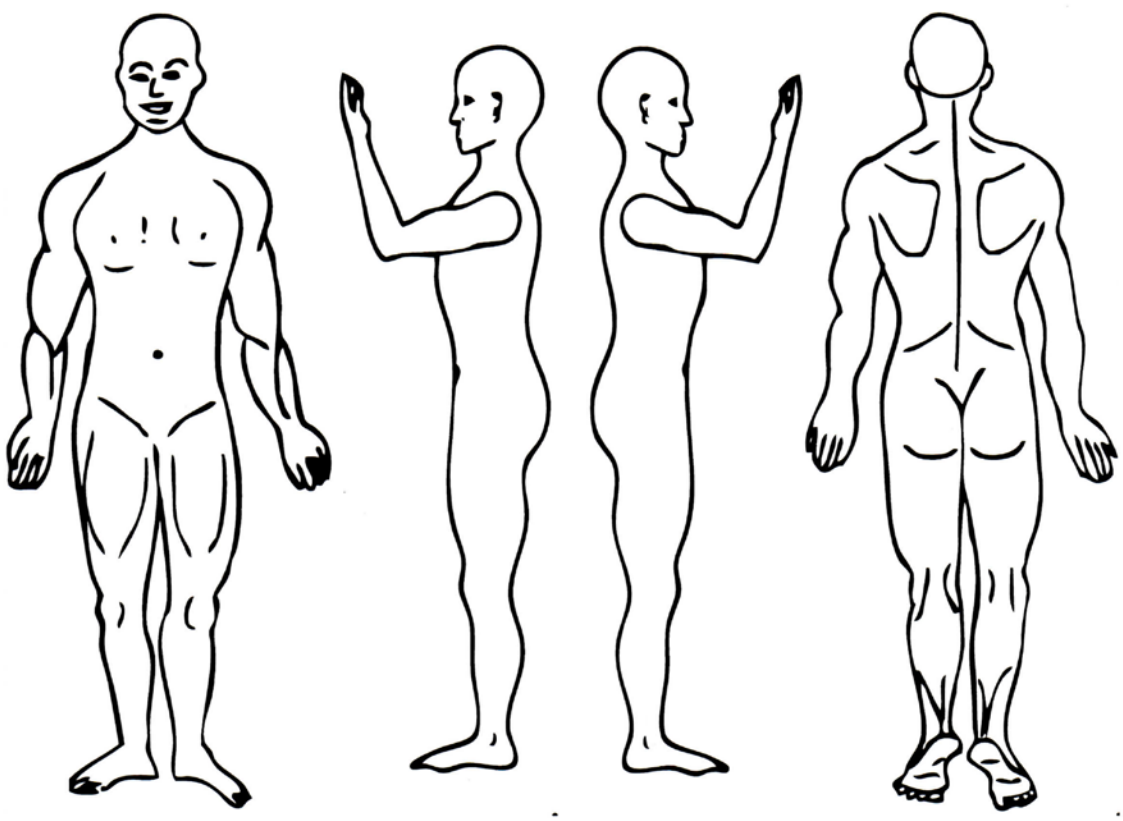
a.) Have you ever had full-body anesthesia (i.e. *to remove tonsils, wisdom teeth,*)?_____
b.) Do you have breast implants?_____ Other surgical implants or prostheses?_____
c.) Have you had elective surgery *(tummy tuck, face-lift, burned off moles, liposuction, etc.)*?_____
d.) Do you have any metal or plastic inside your body *(such as pins, clamps, plates, etc.)*?_____
e.) Do you have pierced ears or other body piercings?_____ tattoos?_____

6. Scars: Use the chart on the next page to 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? _____

SURGERY/SCAR/TRAUMA CHART



Directions

All Scars: Please draw a 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 an **X** where you have had trauma even it if 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, 1998.")

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 extractions 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 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)*?_____

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? _____
Roach/Ant Spray? _____ 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?_____

_____

_____

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 TOP 3 health goals? (What do you really want?)

1.

2.

3.

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.)

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

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