

## Health Evaluation Profile

### PART 1: GENERAL INFORMATION

Name: \_\_\_\_\_ DOB&Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone \_\_\_\_\_

Email: \_\_\_\_\_

Referred By: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Do you currently take vitamins or other supplements:  No  Yes

If Yes, please list \_\_\_\_\_

\_\_\_\_\_

Reason for seeking information:-

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART 2: MEDICATIONS:** Check any of the following conditions or medications you are taking.

Antacids

Antibiotics

Antidepressants

Anti-Inflammatory Medication

Laxatives

Water Retention

Heart medications

Steroids

High Blood Pressure Meds

Hormones

Ulcer Medications

Oral Contraceptives

Radiation &/Chemotherapy

Thyroid

Others (please list)

This information is provided for nutritional information. I am taking my blood sample to be used in live cell education. The information I am seeking is of an educational and nutritional nature and not a medical diagnosis.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PART 3: SYMPTOMATIC SELF EVALUTION:** Each of the following sections contains questions regarding your evaluation of conditions that may be affecting your health and personal well being. Check the box in each column that describes your situation. Leave questions blank that you are not sure of. For questions with only a “No” or “Yes”, use column 1 for “No” and column 2 for “Yes”

How often do you do a strength training program? Never  Sometimes Often

How often do you do an aerobics program? Never  Sometimes Often

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**Section 2:**

	Yes or		
	No	/Sometimes/	Often
1. Do you experience bloating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you feel too full after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel sleepy or have low energy after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any uncomfortable or adverse reactions after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your diet consist of highly processed and cooked foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel a need to eliminate soon after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have diarrhea after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel flush after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty breathing after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have undigested food pass through?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you get indigestion after eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 3:**

	Yes or		
	No	/Sometimes/	Often
1. Do you have age spots?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have hemorrhoids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you get bloody noses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have varicose veins or bruise too easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have deteriorating eye sight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you experience hyperactivity or excessive nervousness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have bleeding gums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have excessive wrinkling of the skin/pre-mature again?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have stiff joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you smoke or are you exposed to 2 <sup>nd</sup> hand smoke or smog?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you constantly around computers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you spend most of your time in a city environment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**PART 3: (Continued)**

**Section 4:**

	Yes or		
	No	Sometimes	Often
1. Do you have persistent leg cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have poor stamina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have excessive hair loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have premature graying of the hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have trouble sleeping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do your muscles feel weak after performing in usual daily activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a craving for alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have an unbalanced diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a small appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel nervous and an inability to concentrate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 5:**

	Yes or		
	No	Sometimes	Often
1. Do you have cravings for sweets or sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you experience weakness or faintness between meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have the inability to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you experience excessive fatigue during workouts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you feel you have unstable blood sugar levels?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you feel dizziness or ringing in the ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have cravings for fatty foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have the inability to lose unwanted fat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have an excessive appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you feel that your muscles are not reaching training goals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have pains in the upper right quadrant of the stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Is your triglyceride level above 115?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section 6:**

	Yes or		
	No	Sometimes	Often
1. Do you feel you have PMS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you moody?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have monthly cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a low sex drive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have poor sex organ development?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you experience a persistent level of low energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have pale skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you uncomfortable no matter what?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have cracking around the lips or a white tongue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART 3: (Continued)**

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**Section 7:**

	Yes or		
	No	Sometimes	Often
1. Are you taking or have you taken antibiotics within the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you undergone any surgery in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have persistent diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get sick often ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have frequent cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a history of food poisoning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you consume alcohol or carbonated beverages/soda?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you done any foreign travel within the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have persistent flatulence or gas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you consume dairy products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 8:**

	Yes or		
	No	Sometimes	Often
1. Are you under 18 years old, pregnant or an endurance athlete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have low energy, fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you eat a low fiber diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you eat a low carbohydrate diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have clammy skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have persistent shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have ridges in your fingernails?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you experience excessive menstrual flow?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 9:**

	Yes or		
	No	Sometimes	Often
1. Do you have high cholesterol (above 200)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have pain in the upper right quadrant of your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you experience distress from eating fatty foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have dry skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have an unpleasant taste in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have persistent burning in your stomach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have flatulence or gas after meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you eat a high fat diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a diet high in hydrogenated fats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you eat red meats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 10:**

	Yes or		
	No	Sometimes	Often
1. Have you had a traumatic injury within the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have muscle pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have muscle cramps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have cold hands and feet or experience poor circulation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have pain in the joints in your legs, arms, hands, or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**PART 3: Section 10 (Continued)**

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	Yes or		
	No	Sometimes	Often
6. Are your injuries slow to heal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have disc problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you experiencing difficulty in strengthening muscles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have frequent fevers or infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you eat a lot of protein (more than 6oz. per day)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 11:**

	Yes or		
	No	Sometimes	Often
1. Do you work around toxic or noxious chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you smoke or are you exposed to 2 <sup>nd</sup> hand smoke or smog?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you taken prescription drugs within the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you regularly experience constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have symptoms of bowel irritation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you a heavy red meat eater?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have stomach aches in the naval area?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have difficulty in thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have discoloration of the gums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have difficulty in responding to conventional treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**Section 12:**

	Yes or		
	No	Sometimes	Often
1. Do you have persistent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have yeast infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are antibiotics ineffective for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you seem to get sick easily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have candida?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have fungus problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have athletes foot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have anal itching?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have food allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have joint pain anywhere in your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**COMMENTS:**

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