

Nutrition Evaluation Profile

NAME _____ PHONE # _____ DATE _____

ADDRESS _____

E-Mail _____

Age _____ Sex _____ Height _____ Weight _____ Blood Type _____ Occupation _____

Do you like your job? _____ Are you generally happy with life? _____

Ages of children? _____ Are you a caregiver for anyone else? _____

DESCRIBE YOUR NORMAL DAYS EATING TO ME:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

PLEASE DESCRIBE YOUR NORMAL DAYS FLUID INTAKE TO ME:

Water _____ (filtered?) _____ Alcohol _____ Coffee/Tea _____

Diet Soda _____ Juice _____ Milk _____ Other _____

How much sleep do you average? _____ Is it sound? _____ What time do you awaken? _____

Do you wake to void? _____ How many times? _____ Do you have urgency? _____

Describe your bowel routine to me _____ X daily, _____ X weekly, consistency _____ Bleeding _____ Pain _____

Tell me about your energy level _____

Do you feel stressed? _____ Nervous _____ What do you do when stressed? _____

How would you describe yourself emotionally? _____

Dental history – fillings _____ crowns _____ root canals _____

other _____

Are you seeing an MD for anything? _____

Surgical history _____

Check any of the medications you are now taking or conditions you experience

- | | | |
|---|--|--|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Water Retention | <input type="checkbox"/> Oral Contraceptives |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Heart Medications | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Radiation and/or Chemotherapy | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Anti-Inflammatory Meds | <input type="checkbox"/> High Blood Pressure Meds | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Ulcer Medications | |

List your current medications? (Please include birth control & over the counter meds) _____

What supplements do you take? _____

Did you take them today? _____

Do you exercise regularly? _____ What type? _____

Please check any of the following that give you problems with any regularity:

<u>Carb. Digestion</u>	<u>Fat Digestion</u>	<u>Protein Digestion</u>	<u>Other issues</u>
<input type="checkbox"/> Airborne allergies	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Moist Tendencies	<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Dry, itchy skin	<input type="checkbox"/> Depression	<input type="checkbox"/> Blood pressure
<input type="checkbox"/> Constipation	<input type="checkbox"/> Tired mid-afternoon	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Bruising
<input type="checkbox"/> Heart weakness	<input type="checkbox"/> Sigh frequently	<input type="checkbox"/> Menstrual concerns	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Respiratory issues	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Menopause Issues	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Dry Tendencies	<input type="checkbox"/> Painful ribs, neck	<input type="checkbox"/> Stress incontinence	<input type="checkbox"/> Irritable if hungry
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Tight shoulders	<input type="checkbox"/> Water retention	<input type="checkbox"/> Numb feet/ hands
<input type="checkbox"/> Starch cravings	<input type="checkbox"/> PMS Sore breasts	<input type="checkbox"/> Back problems	<input type="checkbox"/> Perspire easily
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sore ribs after meals	<input type="checkbox"/> Receding gums	<input type="checkbox"/> Eyes light sensitive
<input type="checkbox"/> where? _____	<input type="checkbox"/> Difficult to inhale	<input type="checkbox"/> TMJ sore jaws	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Bleeding issues	<input type="checkbox"/> Arthritis/ joint pain	<input type="checkbox"/> Do you smoke?

Do you crave foods such as salty crunchy, chocolate, peanut butter, starches, alcohol, sweets? _____

If answering "Yes" what do you crave _____

List other favorite foods _____

Why did you come here today? _____

What is the Most Important issue you would like to have corrected _____

Is there anything else I would benefit from knowing about you or your situation? _____

I understand the above information is provided for nutritional information, that the nutrition consultation, Live Cell Analysis, Urinalyses kit, 2 Body Balance Scans, Sign and Symptoms report and first appointment with a follow-up appointment has a fee of \$579. I also understand the Live Cell Analysis (i.e., Darkfield Microscopy) is a visual tool used to seek nutrition information and not used for medical diagnosis. Nutritional supplements can be purchased from Complete Nutrition Alliance at an additional cost.

The initial fee of \$579 will include 2 appointments. The first appointment will take around 1 ½ - 2 hours depending on the number of questions you may have. The 2nd appointment will take around 1 hour and the lab results, food and supplement suggestions will be discussed at this time.

See Office Explanation of Services and Products for follow-up appointment fees.

Payments accepted are cash, check, Visa, MasterCard and Discover.

Signature _____ Date _____

Print name _____