FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program, personally designed for you.

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: (______) ____________________

Please do not take any supplements for 2 meals before your first evaluation.

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?____________
Do you frequently breathe second-hand smoke from others who are smoking (either at work or at home)?_____________

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 Please describe any scars on your body (major and minor ones):____

____

7. Drugs *This is strictly confidential information.* Do you currently use recreational drugs? ______ *[Circle all that apply: marijuana, cocaine, heroin, uppers, downers]* Others:____________________ How often?______________________
Have you used recreational drugs in the past?________ If yes, for how long?__________________________________

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) eat food 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 organic chicken." Instead of writing "salad," identify what it's made of, such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Olive Oil.") PLEASE BE HONEST!

BREAKFAST (Typical time eaten:_________) ____

____

____

____

LUNCH (Typical time eaten:_________) ____

____

____

____

DINNER (Typical time eaten:_________) ____

____

____

____

SNACKS (Typical time eaten:_________) ____

____

____

____

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? Check all that apply: *(Please be honest.)*

__ 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 health goals? (What do you *really* want?) ______________________________
____

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.)

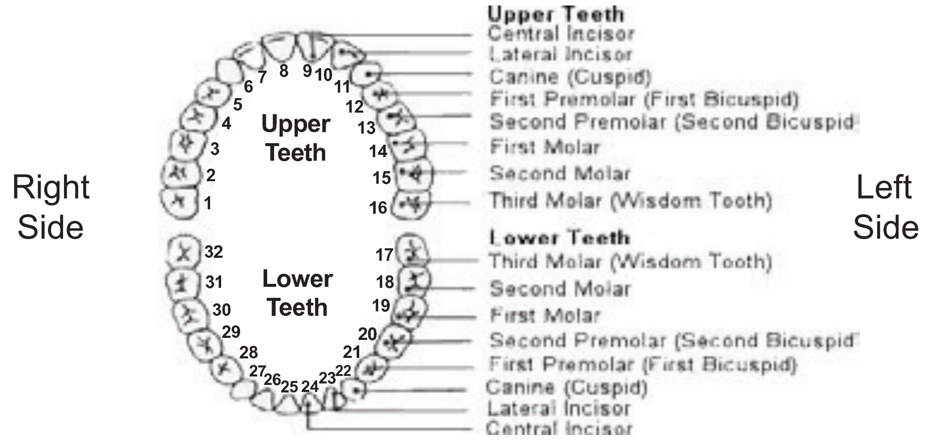
__ age 60-70
__ age 70-80
__ age 80-90
__ age 90-100
__ age 100+

__ as long as I'm healthy
__ as long as I have been granted
__ until I complete my mission (purpose) on earth
__ only if my significant other is still alive also
__ forever
__ it's already enough

Dental History Chart

Name: ______________________________ Date: ________________

Tooth Reference Chart

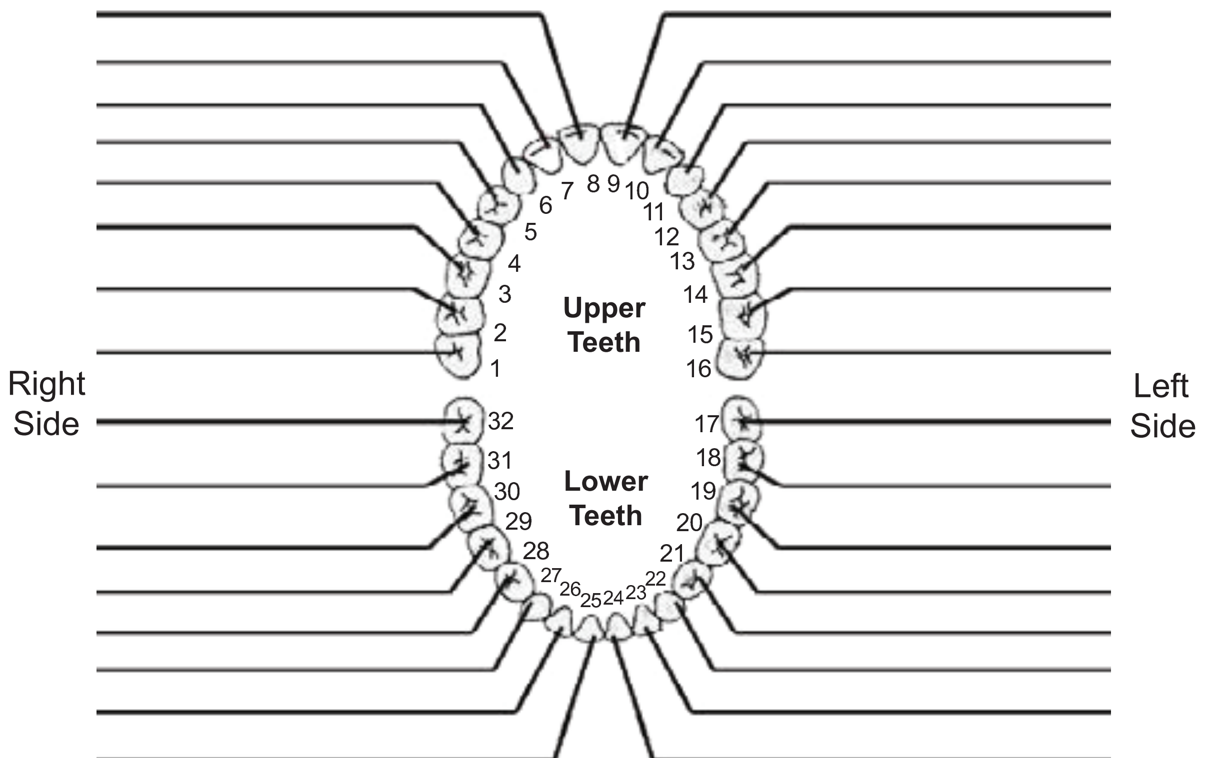


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example Chart on back.**

Please use the following descriptors when filling in the chart:

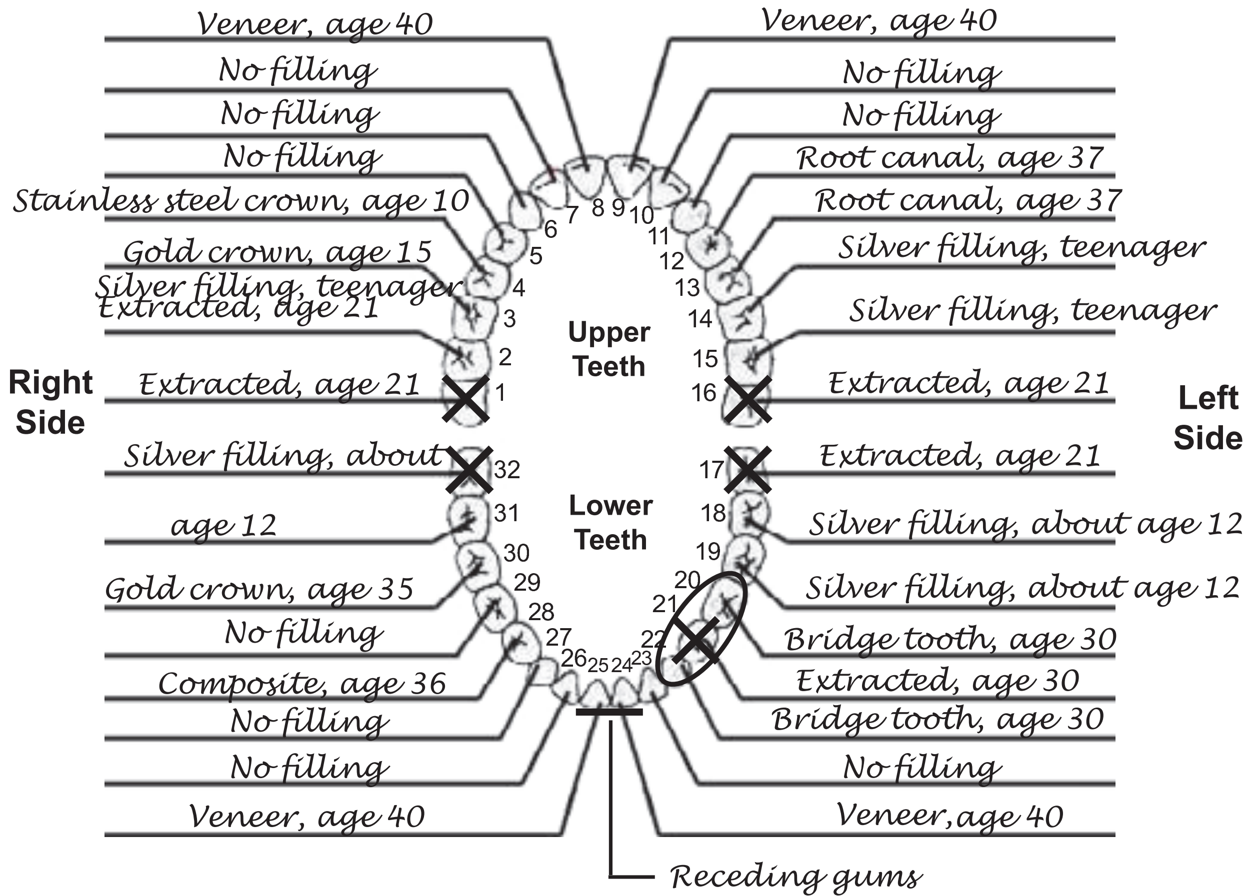
- Silver filling
- Composite filling *(plastic-like filling)*
- Gold crown
- Stainless steel crown
- Root canal
- Post (in root canal)
- Veneers
- Bridge *(circle teeth with bridge attached)*
- Partial denture
- Full denture
- Extracted tooth *(write next to X'd out tooth)*
- No filling

Gum Concerns: please make a line at the base of any teeth that have gum problems and indicate what type of concern, such as deep pockets, receding gums, bleeding gums, etc.



Example Dental Chart

Name: Den Tall **Date:** 01-01-2011

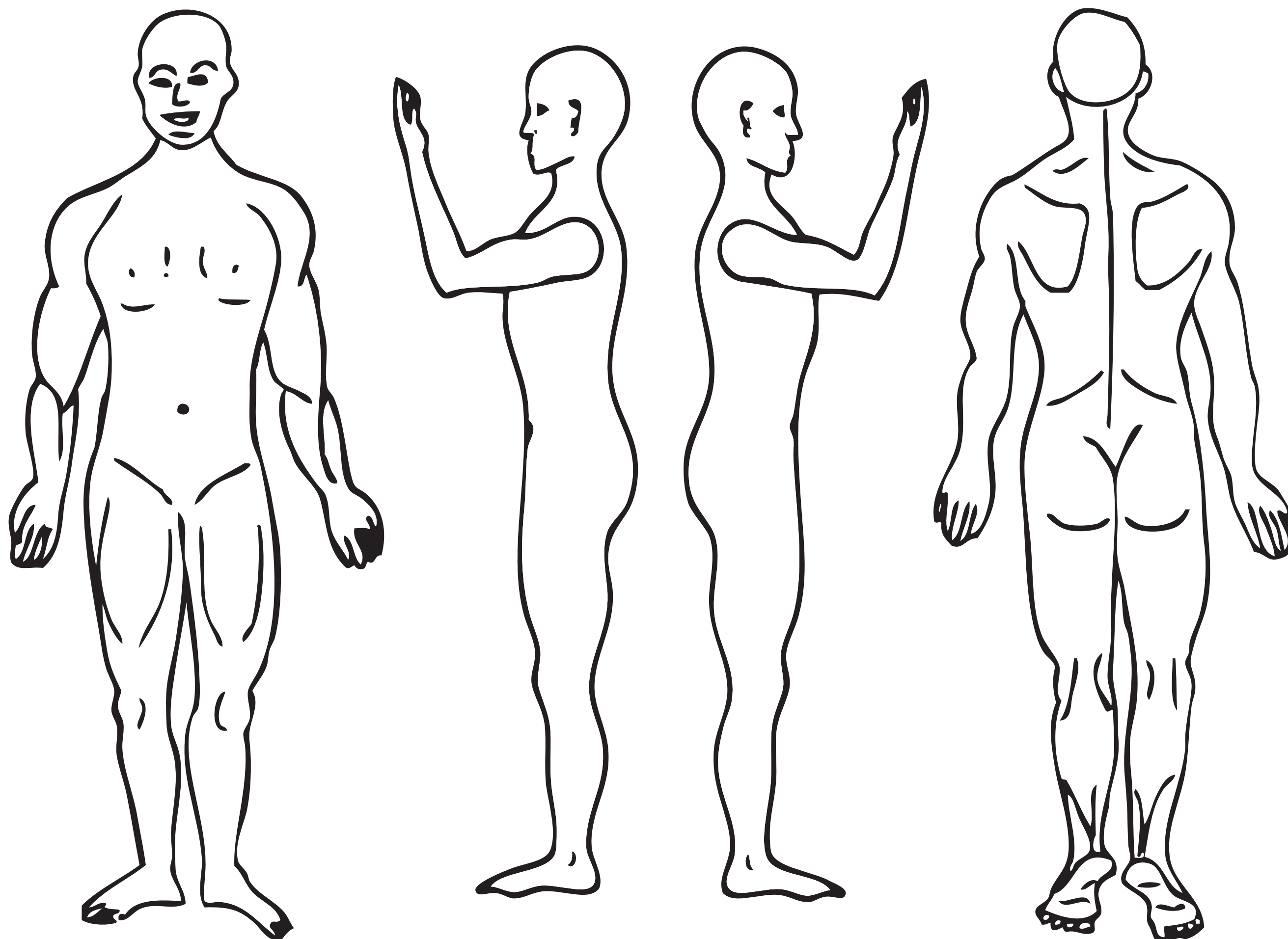


R06-0201

Scar/Trauma Chart

Name: ____

Date: __________________



Directions

<u>All Scars</u>. Please draw a red 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.

<u>All Trauma Areas</u>. Please put a red X where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

<u>Internal Metal</u>: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

<u>Date of injury and type of injury</u>. 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, 1988.")

Rev. 07-18-07

Informed Consent

For Nutritional Consultation

Health By Daniel LLC, QRA

Advanced Nutritional Programs

I acknowledge that Health By Daniel LLC and its staff members are not medical doctors. I understand that Health By Daniel LLC and its staff members provide nutritional and other health-related information to help me attain and maintain my best health. Health By Daniel LLC will help determine which nutrients my body needs bolstered. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that Health By Daniel LLC and its staff members do NOT diagnose, treat, cure or claim to cure cancer or any other disease.

Consultation Fees

The consultation fee for Health By Daniel LLC is $180.00 per hour (based upon 55 minutes per hour), prorated for the actual time spent with the client. The initial visit typically takes about 2 hours which includes a thorough review of present nutritional concerns and an advanced, comprehensive nutritional program including recommended state-of-the-art nutritional supplements. Nutritional testing will be performed to pinpoint-target special body needs. In addition, QRA[SM] Kinesiological testing may be used to help identify specific needs and interference fields. Follow- up appointments are usually recommended at 4-8 week intervals and average 60 minutes or less per session, depending on the extent of each client's needs and concerns. In special cases, weekly appointments may be recommended.

Nutritional Supplement Purchases: I understand that the cost of nutritional supplements is separate from consultation fees.

Returned Checks: If paying by check, I understand that an additional $30.00 processing fee will be assessed for each returned check or "stop payment" check.

Scheduling Policy

I understand that Health By Daniel LLC's Office will call me 24 hours prior to my appointment to confirm. I understand that if I want to reschedule or cancel my appointment for any reason, it is my responsibility to call the office during business hours, 1 business day or more in advance of my scheduled appointment. I understand that if I fail to reschedule or cancel my appointment at least 1 business day in advance of my scheduled appointment, there is a $180.00 non-refundable processing fee. I understand that leaving a voicemail or sending an e-mail message to reschedule or cancel my appointment is not acceptable.

"Essentials Only" Program

I understand I may request an "Essentials Only" Nutritional Program with an abbreviated consultation time, such as 30 minutes. This program will provide essential nutritional recommendations, including recommended nutritional supplements. The fee for this program is the same as above ($180.00 per hour), but prorated for the actual time spent. If I wish to have an "Essentials Only" Program, I understand I need to indicate this when I schedule my appointment.

Informed Consent

For Nutritional Consultation

Health By Daniel LLC, QRA

Time Allotment

I understand it is my responsibility to observe the length of time my consultation is taking. Although Health By Daniel LLC is glad to answer questions as the consultation proceeds, it naturally extends the length of the consultation time. I understand that if I do not wish to go beyond a certain time limit, I need to inform Health By Daniel LLC before the consultation begins.

Interruptions

Due to the busy nature of Health By Daniel LLC's office, I understand there may be occasional interruptions during my consultation time. If this happens, the number of minutes of the interruption will be deducted from my total time. Health By Daniel LLC and its staff apologize for any inconvenience.

Follow-Up

I understand that any questions I may have should be asked during my consultation time. If I have questions after the consultation, I understand that I should schedule a telephone consultation with Health By Daniel LLC (See below.)

Telephone Consultation and Emergencies

I understand that if I have any questions between scheduled visits, or if an emergency arises, or if I would just like to speak personally to Health By Daniel LLC, I will need to call to schedule a 15 minute consultation time (or longer). Health By Daniel LLC will then answer my questions during this brief consultation time. Consultation fees are calculated at $45.00 per 15 minutes.

Nutritional Supplement Policy

I understand that while I am under the care of Health By Daniel LLC, I agree to purchase my nutritional supplements and place my orders through them rather than Healthline for a period of six months. This helps to assure that my nutritional program will proceed smoothly.

Consent. I have read this Informed Consent and understand it. I am not a minor (under the age of 18). Additionally, I am here on this day and any subsequent visit, solely on my own behalf and not as an agent for any federal, state or local agencies on a mission of entrapment or investigation and I also certify that I am signing my own true given, legal name and not an alias or a pseudo or false name.

Signature______________________________ Date_________________

Printed Name__________________________

Witness________________________________ Date________________