# **EVALUATION FORM**

GENERAL INFORMATION

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL PHONE NUMBER \_\_\_\_-\_\_\_\_- \_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE \_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER\_\_\_\_\_\_\_ HEIGHT\_\_\_\_\_\_\_ WEIGHT\_\_\_\_\_\_\_ HAIR COLOR\_\_\_\_\_\_\_ HAIR TYPE\_\_\_\_\_\_\_

REFERRED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST YOUR MAJOR HEALTH CONCERNS IN ORDER OF IMPORTANCE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST YOUR MAJOR HEALTH GOALS IN ORDER OF IMPORTANCE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU TAKING OR HAVE YOU EVER TAKEN BIRTH CONTROL? COPPER IUD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 

DO YOU HAVE ANY SILVER AMALGAM FILLINGS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ROOT CANALS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY MEDICAL DEVICES OR MEDICAL IMPLANTS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE A HIGH LEVEL OF STRESS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SLEEP WELL AT NIGHT? HOW MANY HOURS PER NIGHT DO YOU SLEEP? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW MUCH WATER DO YOU CONSUME PER DAY? WHAT TYPE OF WATER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU CRAVE CERTAIN FOODS? IF SO, WHAT ARE THEY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU CONSTIPATED OR DO YOU HAVE LOOSE BOWEL MOVEMENTS? HOW OFTEN DO YOU HAVE BOWEL MOVEMENTS PER DAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT TYPE OF EXERCISE DO YOU DO? HOW MANY TIMES PER WEEK DO YOU EXERCISE?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH YOU WOULD LIKE TO SHARE WITH ME?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that Kelley McConnell perform a nutritional evaluation and set up a diet and supplement program for the purpose of enhancing health and improving well being. I understand that nutritional analysis is a means to reduce stress by identifying and correcting nutritional deficiencies and imbalances. It is not intended as diagnosis, treatment or prescription for any condition or disease. Kelley McConnell provides this service as an unlicensed nutritional consultant. Check with your healthcare professional if you are not sure if you should use any supplements, dietary recommendations or detoxification methods that are recommended.

SIGNITURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for inviting me to be part of your healing journey to *RESTORE* your body in balance!

You should receive your program within 3 weeks of mailing this form with your sample and payment.  ****

**SYMPTOMS and CONDITIONS**

***PLACE A CHECK* next to any conditions or symptoms that describe you presently.**

***CIRCLE* any past conditions or symptoms.**

***PLACE A STAR* next to the conditions or symptoms most important to you.**

\_\_­\_Joint Pain \_\_\_Bronchitis \_\_\_Depression \_\_\_Gall Stones

\_\_\_Joint Stiffness \_\_\_Asthma \_\_\_Irritability \_\_\_Fissures

\_\_\_Arthritis, Osteo \_\_\_Post-Nasal Drip \_\_\_Mind Races \_\_\_Hemorrhoids

\_\_\_Arthritis, Rheumatoid \_\_\_Sinus Congestion \_\_\_Mood Swings \_\_\_Cirrhosis

\_\_\_ Pain \_\_\_Allergies \_\_\_OCD \_\_\_Diverticulitis

\_\_\_Muscle Weakness \_\_\_Emphysema \_\_\_Panic Attacks \_\_\_Tend to lose weight

\_\_\_Muscle Cramps \_\_\_Fatigue \_\_\_Poor Memory \_\_\_Anemia

\_\_\_Bursitis \_\_\_Hypothyroidism \_\_\_Schizophrenia \_\_\_Easy Bruising

\_\_\_Fractures \_\_\_Low Body Temp \_\_\_Trouble Sleeping \_\_\_Drug Addiction

\_\_\_Osteoporosis \_\_\_Cold/Dry Skin \_\_\_Autism \_\_\_Alcoholism

\_\_\_Gout \_\_\_Tend to Gain Weight \_\_\_Attention Deficit \_\_\_Smoking

\_\_\_Sweet Cravings \_\_\_Hyperthyroidism \_\_\_Hyperkinesis

\_\_\_Sugar Reactions \_\_\_Acne \_\_\_Dyslexia **WOMEN:**

\_\_\_Irritable Before Meals \_\_\_Eczema \_\_\_Seizures \_\_\_PMS

\_\_\_Can’t Skip Meals \_\_\_Fungal Issues \_\_\_Learning Disability \_\_\_Cramps

\_\_\_Hypoglycemia \_\_\_Infections/Candida \_\_\_Mental Retardation \_\_\_No Menstruation

\_\_\_Crave Starches \_\_\_Psoriasis \_\_\_Delayed Development \_\_\_Heavy Periods

\_\_\_Fat Cravings \_\_\_Hives \_\_\_Bladder Infections \_\_\_Light/Irregular Periods

\_\_\_Other Food Cravings \_\_\_Hair Loss \_\_\_Kidney Infections \_\_\_Ovarian Cysts

\_\_\_Food Allergies \_\_\_Slow Wound Healing \_\_\_Trouble Urinating \_\_\_Fibroid Tumors

\_\_\_Excessive Hunger \_\_\_Cataracts \_\_\_Frequent Urination \_\_\_Abnormal Pap Smear

\_\_\_No Hunger \_\_\_Glaucoma \_\_\_Painful Urination \_\_\_Menopause

\_\_\_Diabetes \_\_\_Meniere’s Disease \_\_\_Kidney Stones \_\_\_Fibrocystic Breasts

\_\_\_Rapid Heart Rate \_\_\_Tooth Decay \_\_\_Water Retention \_\_\_Breast Tumors

\_\_\_Skipped Heart Beats \_\_\_Excessive Plaque teeth \_\_\_Sinus Headache \_\_\_Yeast Infections

\_\_\_Heart Palpitations \_\_\_Gum Disease \_\_\_Tension Headache \_\_\_Hot Flashes

\_\_\_Heart Attack \_\_\_Infections/Viruses \_\_\_Migraine Headache \_\_\_Infertility

\_\_\_Poor Circulation \_\_\_Tumors/Cancer \_\_\_Neuritis

\_\_\_Dizziness \_\_\_Multiple Sclerosis \_\_\_Constipation **MEN:**

\_\_\_Low or High Blood Pressure \_\_\_Parkinson’s Disease \_\_\_Diarrhea \_\_\_Prostate Problems

\_\_\_Angina \_\_\_Scleroderma \_\_\_Intestinal Gas \_\_\_Impotence

\_\_\_Arteriosclerosis \_\_\_ALS \_\_\_Bloating

\_\_\_High Cholesterol \_\_\_Anger \_\_\_Heartburn

\_\_\_High Triglycerides \_\_\_Anxiety \_\_\_Ulcer

\_\_\_Cough \_\_\_Bipolar Disorder \_\_\_Stomach Pain

\_\_\_Confusion \_\_\_Brain Fog \_\_\_Colitis

 