# 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:

_____
_____

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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 health.

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

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**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
___Joint Stiffness
___Arthritis, Osteo
___Arthritis, Rheumatoid
___ Pain
___Muscle Weakness
___Muscle Cramps
___Bursitis
___Fractures
___Osteoporosis
___Gout
___Sweet Cravings
___Sugar Reactions
___Irritable Before Meals
___Can't Skip Meals
___Hypoglycemia
___Crave Starches
___Fat Cravings
___Other Food Cravings
___Food Allergies
___Excessive Hunger
___No Hunger
___Diabetes
___Rapid Heart Rate
___Skipped Heart Beats
___Heart Palpitations
___Heart Attack
___Poor Circulation
___Dizziness
___Low or High Blood Pressure
___Angina
___Arteriosclerosis
___High Cholesterol
___High Triglycerides
___Cough
___Confusion

___Bronchitis
___Asthma
___Post-Nasal Drip
___Sinus Congestion
___Allergies
___Emphysema
___Fatigue
___Hypothyroidism
___Low Body Temp
___Cold/Dry Skin
___Tend to Gain Weight
___Hyperthyroidism
___Acne
___Eczema
___Fungal Issues
___Infections/Candida
___Psoriasis
___Hives
___Hair Loss
___Slow Wound Healing
___Cataracts
___Glaucoma
___Meniere's Disease
___Tooth Decay
___Excessive Plaque teeth
___Gum Disease
___Infections/Viruses
___Tumors/Cancer
___Multiple Sclerosis
___Parkinson's Disease
___Scleroderma
___ALS
___Anger
___Anxiety
___Bipolar Disorder
___Brain Fog

___Depression
___Irritability
___Mind Races
___Mood Swings
___OCD
___Panic Attacks
___Poor Memory
___Schizophrenia
___Trouble Sleeping
___Autism
___Attention Deficit
___Hyperkinesis
___Dyslexia
___Seizures
___Learning Disability
___Mental Retardation
___Delayed Development
___Bladder Infections
___Kidney Infections
___Trouble Urinating
___Frequent Urination
___Painful Urination
___Kidney Stones
___Water Retention
___Sinus Headache
___Tension Headache
___Migraine Headache
___Neuritis
___Constipation
___Diarrhea
___Intestinal Gas
___Bloating
___Heartburn
___Ulcer
___Stomach Pain
___Colitis

___Gall Stones
___Fissures
___Hemorrhoids
___Cirrhosis
___Diverticulitis
___Tend to lose weight
___Anemia
___Easy Bruising
___Drug Addiction
___Alcoholism
___Smoking

**WOMEN:**
___PMS
___Cramps
___No Menstruation
___Heavy Periods
___Light/Irregular Periods
___Ovarian Cysts
___Fibroid Tumors
___Abnormal Pap Smear
___Menopause
___Fibrocystic Breasts
___Breast Tumors
___Yeast Infections
___Hot Flashes
___Infertility

**MEN:**
___Prostate Problems
___Impotence

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