

Divine Nature



Nutrition Evaluation

"The doctor of the future will give no medication, but will interest his patients in the care of the human frame, diet and in the cause and prevention of disease."

-Thomas Edison

Name: _____ Date: _____

Address: _____ City _____ St _____ Zip _____

Home Phone: _____ Cell _____ Email: _____

Referred by: _____ Age: _____ Birth Date: _____

Male/Female: _____ Height: _____ Weight: _____

Goals/Areas of concern regarding your health: _____

_____**PRESCRIPTION DRUG USAGE - Please check the box if you use any of the following:****A.** Antacids, Zantac, Pepcid AZ, Roloids, etc
 Chemotherapy**B.** Laxatives
 Ulcer medications
 Antibiotic / Antifungal**C.** Anti-diabetic / Insulin**D.** Oral Contraceptives**E.** Hormones**F.** Relaxants / Sleeping Pills Thyroid
 Radiation
 Antidepressants**G.** Aspirin / Acetaminophen Cortisone / Anti-Inflammatory
 Heart Medications
 High Blood Pressure Medicine**Are currently taking any supplements:** _____
_____**DIETARY HABITS: Describe the foods you normally eat:**

BREAKFAST: _____

LUNCH: _____

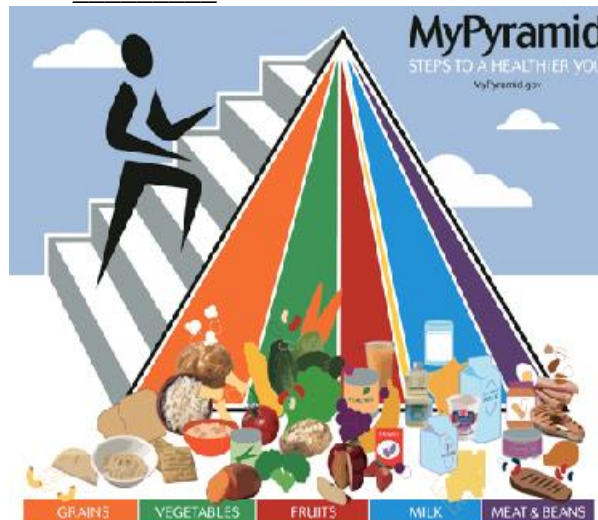
DINNER: _____

SNACKS: _____

Please Circle YES or NO

Do you consume:

- | | | |
|---|-----|----|
| 1. Soda or carbonated beverages of any kind including carbonated water? | YES | NO |
| 2. White flour products? | YES | NO |
| 3. Fried foods? | YES | NO |
| 4. Fast foods regularly? | YES | NO |
| 5. Fifty percent of your food in its raw form? | YES | NO |
| 6. Sugars other than fructose, sucanat, Stevia, or raw organic honey? | YES | NO |
| 7. Artificial sweeteners? | YES | NO |
| 8. Candy? | YES | NO |
| 9. Red meat or pork? | YES | NO |
| 10. Tap water? If no, what type of water _____ | YES | NO |
| 11. Eight to ten glasses of water daily? | YES | NO |
| 12. Coffee? | YES | NO |
| 13. Alcoholic beverages? | YES | NO |
| 14. Artificial colors, flavoring, MSG or preservatives (BHT, etc)? | YES | NO |
| 15. Hydrogenated or partially hydrogenated oils? | YES | NO |
| 16. Any tobacco products? | YES | NO |
| 17. Real butter as opposed to margarine? | YES | NO |
| 18. Oils in the form of extra virgin olive oil and safflower or canola oil daily? | YES | NO |
| 19. One Tbsp. of flax seeds daily? | YES | NO |
| 20. Are you a vegetarian? | YES | NO |
| 21. At least 6 servings of whole grains daily? (Serving size: 1 piece of bread) | YES | NO |
| 22. At least 3 servings of fresh fruit daily? | YES | NO |
| 23. At least 3 servings of fresh vegetables daily? | YES | NO |
| 24. Two to three servings of protein daily (eggs, raw nuts, legumes, beans, lean meat)? | YES | NO |
| 25. Two servings daily of dairy (low-fat milk, cottage cheese, yogurt, etc)? | YES | NO |
| 26. Mainly grains, some fruits & vegetables, a small amount of dairy and protein and minimal fats, oils and sweets daily? | YES | NO |
| 27. Are you currently involved in an aerobic exercise program?
If yes, how many days/week? _____ | YES | NO |
| 28. Are you currently involved in a strength-training program?
If yes, how many days/week? _____ | YES | NO |





INSTRUCTIONS: Circle the best answer that describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank. Repeated questions should be answered as they appear.

N-0 = NO

Y-2 = YES

S-1 = SOMETIMES

**Total each section when you complete the evaluation*

<p>Section 1 – TOTAL DIGESTIVE ENZYMES</p> <p>Do you experience bloating? N-O Y-2 S-1</p> <p>Fullness for extended time after meals? N-O Y-2 S-1</p> <p>Sleepy or low energy after eating? N-O Y-2 S-1</p> <p>Do you experience indigestion or take antacids? N-O Y-2 S-1</p> <p>Uncomfortable/adverse reactions to food? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals</p> <p>5-8 2 capsules - 3x/day - with meals</p> <p>9-15 3 capsules - 3x/day - with meals</p>
<p>Section 2 – MULTI-VITAMIN and/or NATURE'S FRUIT & VEGETABLE</p> <p>Do you have varicose veins/bruise easily? N-O Y-2 S-1</p> <p>Do you have poor stamina? N-O Y-2 S-1</p> <p>Do you have persistent leg cramps? N-O Y-2 S-1</p> <p>Are you nervous/have poor concentration? N-O Y-2 S-1</p> <p>Is your vision failing rapidly? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals</p> <p>5-8 2 capsules - 2x/day - with meals</p> <p>9-15 3 capsules - 3x/day - with meals</p>
<p>Section 3 – OMEGA 3-6-9</p> <p>Do you have dry skin? N-O Y-2 S-1</p> <p>Do you experience grinding in your joints? N-O Y-2 S-1</p> <p>Days without eating avocados, raw nuts flax seeds(oil), etc? N-O Y-2 S-1</p> <p>Do you suffer from learning disabilities or poor concentration? N-O Y-2 S-1</p> <p>Are you overweight? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals</p> <p>5-8 1 capsule - 3x/day - with meals</p> <p>9-15 2 capsules - 3x/day - with meals</p>
<p>Section 4 - FAT & SUGAR ENZYMES</p> <p>Do you crave sweets & sugars? N-O Y-2 S-1</p> <p>Do you feel weak/faint between meals? N-O Y-2 S-1</p> <p>Is your triglyceride level over 175? N-O Y-2 S-1</p> <p>Are you unable to lose or gain weight? N-O Y-2 S-1</p> <p>Family history of diabetes? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals</p> <p>5-8 2 capsule - 2x/day - with meals</p> <p>9-15 2 capsules - 3x/day - with meals</p>
<p>Section 5 – SUGAR/STARCH</p> <p>Are you a Diabetic? N-O Y-2</p> <p>Does your diet consist of processed sugars or starches such as white flour, white-bread & pastas ? N-O Y-2 S-1</p> <p>Are you Hyperglycemic? N-O Y-2</p> <p>Do you experience poor circulation? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1 1 capsule - 1x/day - with meals</p> <p>2-7 1 capsule - 2x/day - anytime</p>

<p>Section 6 – WEIGHT LOSS</p> <p>Do you struggle with Portion-Control? N-O Y-2 S-1 Do you find it hard to lose weight? N-O Y-2 S-1 Is Belly Fat a concern? N-O Y-2 S-1 Do you consume processed fats? N-O Y-2 S-1</p> <p style="text-align: center;">Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-15 1 capsule - 2x/day – between meals</p>
<p>Section 7 – INFLAMMATION RESPONSE</p> <p>Have you been on a high-protein diet or eat more than 6 oz or protein a day? N-O Y-2 S-1 Are your injuries slow to heal? N-O Y-2 S-1 Do you have frequent fevers or infections? N-O Y-2 S-1 Do you have muscle cramps or pain? N-O Y-2 S-1 Have you been injured within last 3 months? N-O Y-2 S-1 Do you experience poor circulation? N-O Y-2 S-1</p> <p style="text-align: center;">Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals 5-8 2 capsule - 2x/day - with meals 9-15 2 capsules - 3x/day - with meals</p>
<p>Section 8 – MAINTAIN FORTIFY BUILD</p> <p>Do you work out? N-O Y-2 S-1 Do you find it hard to gain muscle? N-O Y-2 S-1 Do you find it hard to maintain muscle? N-O Y-2 S-1 Are you recovering from surgery/injury? N-O Y-2 S-1 Do you have a long term digestive issue? N-O Y-2 S-1 Do you have problems maintaining the proper PH balance in your body? N-O Y-2 S-1</p> <p style="text-align: center;">Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals 4-15 2 capsules - 3x/day - with meals</p> <p>*For strength training/muscle building take 6 capsules before a workout & 6 capsules after a workout. **Additionally, take 6 capsules 1x/daily on non-work out days.</p>
<p>Section 9 – NATURE’S JOINT RELIEF</p> <p>Do you have chronic pain? N-O Y-2 S-1 Do you have bursitis? N-O Y-2 S-1 History of joint injury? N-O Y-2 S-1 Do you have swollen joints/arthritis? N-O Y-2 S-1 Do you have increased flexibility in your joints (double-jointed)? N-O Y-2 S-1</p> <p style="text-align: center;">Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals 5-8 2 capsules - 3x/day - with meals 9-15 3 capsules - 3x/day - with meals</p>
<p>Section 10 - LIVER/KIDNEY (not recommended during pregnancy)</p> <p>Are the whites of your eyes yellowish? N-O Y-2 S-1 Do you experience back pain over kidneys? N-O Y-2 S-1 Do you have strong-smelling urine? N-O Y-2 S-1 Do you take anti-inflammatory drugs? N-O Y-2 S-1 Do you have age spots? N-O Y-2 S-1</p> <p style="text-align: center;">Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - between meals 5-8 2 capsules - 2x/day - between meals 9-15 3 capsules - 3x/day - between meals</p> <p>*As a cleanse, take 2 capsules at bedtime until bottle is finish. **All individuals should cleanse every 6 months -1 year</p>

<p>Section 11 – NATURE’S IRON</p> <p>Do you have anemia? N-O Y-2 S-1 Is your skin clammy? N-O Y-2 S-1 Do you have frequent headaches? N-O Y-2 S-1 Do you experience low energy or fatigue? N-O Y-2 S-1 Do you exercise over 6 hours a week? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals 5-8 2 capsules - 2x/day - with meals 9-15 2 capsules - 3x/day - with meals</p>
<p>Section 12 –NATURE’S PROBIOTIC</p> <p>Do you consume dairy products, meat and/or poultry? N-O Y-2 S-1 Are you taking or have taken antibiotics within the last 90 days? N-O Y-2 S-1 Do you have a history of food poisoning? N-O Y-2 S-1 Traveled overseas in last 3 months? N-O Y-2 S-1 Do you have persistent gas? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-2 1 capsule - 1x/day - with meals 3-15 2 capsule - 1x/day - with meals</p>
<p>Section 13 – OSTEO REPAIR (not recommended during pregnancy)</p> <p>Have you had any hormonal problems? N-O Y-2 S-1 Do you have osteoporosis? N-O Y-2 S-1 Days without eating raw leafy green vegetables? N-O Y-2 S-1 Are you over 50? N-O Y-2 S-1 Do you have a small frame or low weight? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals 5-8 2 capsule - 2x/day - with meals 9-15 2 capsules - 3x/day - with meals</p>
<p>Section 14 - PROSTATE SUPPORT (MALES ONLY this section)</p> <p>Does your bladder always feel full? N-O Y-2 S-1 Do you experience inconsistent pressure or pain during urination? N-O Y-2 S-1 Does ejaculation cause pain? N-O Y-2 S-1 Do you experience low sex drive? N-O Y-2 S-1 Do you have premature ejaculation? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 1x/day - with meals 5-8 1 capsules - 2x/day - with meals 9-15 1 capsules - 3x/day - with meals</p>
<p>Section 15 - FEMALE HORMONE BALANCE (FEMALES ONLY this section)</p> <p>Do you experience depression, moodiness/irritability? N-O Y-2 S-1 Do you have heavy menstrual bleeding? N-O Y-2 S-1 Do you have monthly cramps? N-O Y-2 S-1 Do you have tender breasts? N-O Y-2 S-1 Are you postmenopausal? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 1x/day - with meals 5-8 1 capsules - 2x/day - with meals 9-15 1 capsules - 3x/day - with meals</p>
<p>Section 16 – INTESTINAL CLEANSE & REPAIR</p> <p>Are you ever constipated? N-O Y-2 S-1 Do you ever experience diarrhea? N-O Y-2 S-1 Do you take laxatives? N-O Y-2 S-1 Day or days without a bowel movement? N-O Y-2 S-1 Have you been exposed to metal toxicity? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-2 1 capsule - 2x/day - with meals 3-8 1 capsule - 3x/day - with meals 9-15 2 capsules - 3x/day - with meals</p>

<p>Section 17 – ENERGY/CLARITY</p> <p>Do you experience tiredness during day? N-O Y-2 S-1 Do you experience loss of mental clarity? N-O Y-2 S-1 Do you find it difficult to make decisions? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-2 1 capsule - 2x/day - with breakfast & lunch 3-6 2 capsule - 2x/day - with breakfast & lunch</p>
<p>Section 18 – NATURE’S C CHEWABLES</p> <p>Do you experience bleeding gums? N-O Y-2 S-1 Do you experience frequent colds or flu like symptoms? N-O Y-2 S-1 Days without fresh fruit? N-O Y-2 S-1 Do you currently take a synthetic Vitamin C supplement (ex. Ascorbic acid)? N-O Y-2 S-1 Do you or have you had cancer? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 tablet - 2x/day - with meals 5-8 2 tablets - 2x/day - with meals 9-15 2 tablets w/ breakfast, 1 tablet w/ dinner</p>
<p>Section 19 – ADRENAL SUPPORT</p> <p>Do you experience light headedness when standing up? N-O Y-2 S-1 Do you rely on coffee, tea or soda to make it through the day? N-O Y-2 S-1 Do you experience high stress levels? N-O Y-2 S-1 Are you an adrenaline junkie? N-O Y-2 S-1 Is it difficult for you to maintain or gain weight?? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals 5-8 2 capsule - 2x/day - with meals 9-15 2 capsules - 3x/day - with meals</p>
<p>Section 20 - IMMUNE SUPPORT(not recommended during pregnancy; 30 days max, min 10 day off)</p> <p>Do you have prolonged exposure to sun? N-O Y-2 S-1 Do you consume alcohol? N-O Y-2 S-1 Are you exposed to toxic substances? (fumes, chemicals, smoke, etc) N-O Y-2 S-1 Are you currently being treated with medications? N-O Y-2 S-1 Do you partake in strenuous activities for more than 1 hour at a time? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals 5-8 2 capsules - 3x/day - with meals 9-15 3 capsules - 3x/day - with meals</p>

<p>Section 21 – NATURE’S CALCIUM</p> <p>Do you eat a lot of processed fatty foods? N-O Y-2 S-1</p> <p>Eat more than 3oz servings of protein daily? N-O Y-2 S-1</p> <p>When you grab your wrist, does your finger and thumb easily touch? N-O Y-2 S-1</p> <p>Do you salt your foods? N-O Y-2 S-1</p> <p>Drink caffeinated drinks (coffee, soda, tea)? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 3x/day - with meals</p> <p>5-8 2 capsules - 2x/day - with meals</p> <p>9-15 2 capsules - 3x/day - with meals</p>
<p>Section 22 – CELL REPAIR</p> <p>Exposed to pesticides, paint or hair chemicals? N-O Y-2 S-1</p> <p>Family history of cancer? N-O Y-2 S-1</p> <p>Do you bruise easily? N-O Y-2 S-1</p> <p>Are you sensitive to chemicals or environmental pollution? N-O Y-2 S-1</p> <p>Do you have vision problems? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 capsule - 2x/day - with meals</p> <p>5-8 2 capsules - 2x/day - with meals</p> <p>9-15 2 capsules - 3x/day - with meals</p>
<p>Section 23 – TOTAL NUTRITION</p> <p>Do you enjoy meal replacement shakes? N-O Y-2 S-1</p> <p>Do you work out on a regular basis? N-O Y-2 S-1</p> <p>Are you looking for healthy protein sources? N-O Y-2 S-1</p> <p>Are you an extreme athlete? N-O Y-2 S-1</p> <p>Total Score: _____</p>	<p><u>SCORE</u> <u>RECOMMENDATIONS</u></p> <p>1-4 1 scoop - 1x/day as a meal</p> <p>5-6 2 scoops - 1x/day as a meal</p> <p>7-8 2 scoops - 2x/day as a meal</p>

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- Thomas Edison