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

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HEALTH EVALUATION

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, Rolaids, 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: _____

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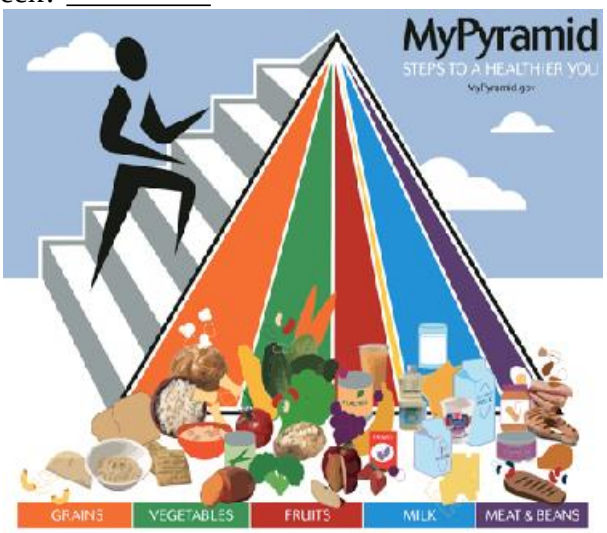
Please Circle YES or NO

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?	YES	NO
If yes, how many days/week? _____		
28. Are you currently involved in a strength-training program?	YES	NO
If yes, how many days/week? _____		



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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*

Section 1 – TOTAL DIGESTIVE ENZYMES				**SCORE**	**RECOMMENDATIONS**
Do you experience bloating?	N-O	Y-2	S-1		
Fullness for extended time after meals?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
Sleepy or low energy after eating?	N-O	Y-2	S-1	5-8	2 capsules - 3x/day - with meals
Do you experience indigestion or take antacids?	N-O	Y-2	S-1	9-15	3 capsules - 3x/day - with meals
Uncomfortable/adverse reactions to food?	N-O	Y-2	S-1		
Total Score:_____					

Section 2 – MULTI-VITAMIN and/or NATURE'S FRUIT & VEGETABLE				**SCORE**	**RECOMMENDATIONS**
Do you have varicose veins/bruise easily?	N-O	Y-2	S-1		
Do you have poor stamina?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Do you have persistent leg cramps?	N-O	Y-2	S-1	5-8	2 capsules - 2x/day - with meals
Are you nervous/have poor concentration?	N-O	Y-2	S-1	9-15	3 capsules - 3x/day - with meals
Is your vision failing rapidly?	N-O	Y-2	S-1		
Total Score:_____					

Section 3 – OMEGA 3-6-9				**SCORE**	**RECOMMENDATIONS**
Do you have dry skin?	N-O	Y-2	S-1		
Do you experience grinding in your joints?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Days without eating avocados, raw nuts flax seeds(oil), etc?	N-O	Y-2	S-1	5-8	1 capsule - 3x/day - with meals
Do you suffer from learning disabilities or poor concentration?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Are you overweight?	N-O	Y-2	S-1		
Total Score:_____					

Section 4 - FAT & SUGAR ENZYMES				**SCORE**	**RECOMMENDATIONS**
Do you crave sweets & sugars?	N-O	Y-2	S-1		
Do you feel weak/faint between meals?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
Is your triglyceride level over 175?	N-O	Y-2	S-1	5-8	2 capsule - 2x/day - with meals
Are you unable to lose or gain weight?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Family history of diabetes?	N-O	Y-2	S-1		
Total Score:_____					

Section 5 – SUGAR/STARCH				**SCORE**	**RECOMMENDATIONS**
Are you a Diabetic?	N-O	Y-2			
Does your diet consist of processed sugars or starches such as white flour, white--bread & pastas ?	N-O	Y-2	S-1	1 2-7	1 capsule - 1x/day - with meals 1 capsule - 2x/day - anytime
Are you Hyperglycemic?	N-O	Y-2			
Do you experience poor circulation?	N-O	Y-2	S-1		
Total Score:_____					

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Section 6 – WEIGHT LOSS				**SCORE**	**RECOMMENDATIONS**
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	1-15	1 capsule - 2x/day – between meals
Is Belly Fat a concern?	N-O	Y-2	S-1		
Do you consume processed fats?	N-O	Y-2	S-1		
Total Score:_____					

Section 7 – INFLAMMATION RESPONSE				**SCORE**	**RECOMMENDATIONS**
Have you been on a high-protein diet or eat more than 6 oz or protein a day?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
Are your injuries slow to heal?	N-O	Y-2	S-1	5-8	2 capsule - 2x/day - with meals
Do you have frequent fevers or infections?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
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		
Total Score:_____					

Section 8 – MAINTAIN FORTIFY BUILD				**SCORE**	**RECOMMENDATIONS**
Do you work out?	N-O	Y-2	S-1		
Do you find it hard to gain muscle?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Do you find it hard to maintain muscle?	N-O	Y-2	S-1	4-15	2 capsules - 3x/day - with meals
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		*For strength training/muscle building take 6 capsules before a workout & 6 capsules after a workout.
Do you have problems maintaining the proper PH balance in your body?	N-O	Y-2	S-1		**Additionally, take 6 capsules 1x/daily on non-work out days.
Total Score:_____					

Section 9 – NATURE'S JOINT RELIEF				**SCORE**	**RECOMMENDATIONS**
Do you have chronic pain?	N-O	Y-2	S-1		
Do you have bursitis?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
History of joint injury?	N-O	Y-2	S-1	5-8	2 capsules - 3x/day - with meals
Do you have swollen joints/arthritis?	N-O	Y-2	S-1	9-15	3 capsules - 3x/day - with meals
Do you have increased flexibility in your joints (double-jointed)?	N-O	Y-2	S-1		
Total Score:_____					

Section 10 - LIVER/KIDNEY (not recommended during pregnancy)				**SCORE**	**RECOMMENDATIONS**
Are the whites of your eyes yellowish?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - between meals
Do you experience back pain over kidneys?	N-O	Y-2	S-1	5-8	2 capsules - 2x/day - between meals
Do you have strong-smelling urine?	N-O	Y-2	S-1	9-15	3 capsules - 3x/day - between meals
Do you take anti-inflammatory drugs?	N-O	Y-2	S-1		
Do you have age spots?	N-O	Y-2	S-1		*As a cleanse, take 2 capsules at bedtime until bottle is finish.
Total Score:_____					**All individuals should cleanse every 6 months -1 year

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Section 11 – NATURE'S IRON				**SCORE**	**RECOMMENDATIONS**
Do you have anemia?	N-O	Y-2	S-1		
Is your skin clammy?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Do you have frequent headaches?	N-O	Y-2	S-1	5-8	2 capsules - 2x/day - with meals
Do you experience low energy or fatigue?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Do you exercise over 6 hours a week?	N-O	Y-2	S-1		
Total Score:_____					

Section 12 –NATURE'S PROBIOTIC				**SCORE**	**RECOMMENDATIONS**
Do you consume dairy products, meat and/or poultry?	N-O	Y-2	S-1	1-2	1 capsule - 1x/day - with meals
Are you taking or have taken antibiotics within the last 90 days?	N-O	Y-2	S-1	3-15	2 capsule - 1x/day - with meals
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		
Total Score:_____					

Section 13 – OSTEO REPAIR (not recommended during pregnancy)				**SCORE**	**RECOMMENDATIONS**
Have you had any hormonal problems?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Do you have osteoporosis?	N-O	Y-2	S-1	5-8	2 capsule - 2x/day - with meals
Days without eating raw leafy green vegetables?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
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		
Total Score:_____					

Section 14 - PROSTATE SUPPORT (MALES ONLY this section)				**SCORE**	**RECOMMENDATIONS**
Does your bladder always feel full?	N-O	Y-2	S-1	1-4	1 capsule - 1x/day - with meals
Do you experience inconsistent pressure or pain during urination?	N-O	Y-2	S-1	5-8	1 capsules - 2x/day - with meals
Does ejaculation cause pain?	N-O	Y-2	S-1	9-15	1 capsules - 3x/day - with meals
Do you experience low sex drive?	N-O	Y-2	S-1		
Do you have premature ejaculation?	N-O	Y-2	S-1		
Total Score:_____					

Section 15 - FEMALE HORMONE BALANCE (FEMALES ONLY this section)				**SCORE**	**RECOMMENDATIONS**
Do you experience depression, moodiness/irritability?	N-O	Y-2	S-1	1-4	1 capsule - 1x/day - with meals
Do you have heavy menstrual bleeding?	N-O	Y-2	S-1	5-8	1 capsules - 2x/day - with meals
Do you have monthly cramps?	N-O	Y-2	S-1	9-15	1 capsules - 3x/day - with meals
Do you have tender breasts?	N-O	Y-2	S-1		
Are you postmenopausal?	N-O	Y-2	S-1		
Total Score:_____					

Section 16 – INTESTINAL CLEANSE & REPAIR				**SCORE**	**RECOMMENDATIONS**
Are you ever constipated?	N-O	Y-2	S-1		
Do you ever experience diarrhea?	N-O	Y-2	S-1	1-2	1 capsule - 2x/day - with meals
Do you take laxatives?	N-O	Y-2	S-1	3-8	1 capsule - 3x/day - with meals
Day or days without a bowel movement?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Have you been exposed to metal toxicity?	N-O	Y-2	S-1		
Total Score:_____					

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Section 17 – ENERGY/CLARITY				SCORE	RECOMMENDATIONS
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	1-2	1 capsule - 2x/day - with breakfast & lunch
Do you find it difficult to make decisions?	N-O	Y-2	S-1	3-6	2 capsule - 2x/day - with breakfast & lunch
Total Score:_____					

Section 18 – NATURE'S C CHEWABLES				SCORE	RECOMMENDATIONS
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	1-4	1 tablet - 2x/day - with meals
Days without fresh fruit?	N-O	Y-2	S-1	5-8	2 tablets - 2x/day - with meals
Do you currently take a synthetic Vitamin C supplement (ex. As ascorbic acid)?	N-O	Y-2	S-1	9-15	2 tablets w/ breakfast, 1 tablet w/ dinner
Do you or have you had cancer?	N-O	Y-2	S-1		
Total Score:_____					

Section 19 – ADRENAL SUPPORT				SCORE	RECOMMENDATIONS
Do you experience light headedness when standing up?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Do you rely on coffee, tea or soda to make it through the day?	N-O	Y-2	S-1	5-8	2 capsule - 2x/day - with meals
Do you experience high stress levels?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
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		
Total Score:_____					

Section 20 - IMMUNE SUPPORT(not recommended during pregnancy; 30 days max, min 10 day off)				SCORE	RECOMMENDATIONS
Do you have prolonged exposure to sun?	N-O	Y-2	S-1		
Do you consume alcohol?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
Are you exposed to toxic substances? (fumes, chemicals, smoke, etc)	N-O	Y-2	S-1	5-8	2 capsules - 3x/day - with meals
Are you currently being treated with medications?	N-O	Y-2	S-1	9-15	3 capsules - 3x/day - with meals
Do you partake in strenuous activities for more than 1 hour at a time?	N-O	Y-2	S-1		
Total Score:_____					

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Section 21 – NATURE'S CALCIUM				**SCORE**	**RECOMMENDATIONS**
Do you eat a lot of processed fatty foods?	N-O	Y-2	S-1		
Eat more than 3oz servings of protein daily?	N-O	Y-2	S-1	1-4	1 capsule - 3x/day - with meals
When you grab your wrist, does your finger and thumb easily touch?	N-O	Y-2	S-1	5-8	2 capsules - 2x/day - with meals
Do you salt your foods?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Drink caffeinated drinks (coffee, soda, tea)?	N-O	Y-2	S-1		
Total Score:_____					

Section 22 – CELL REPAIR				**SCORE**	**RECOMMENDATIONS**
Exposed to pesticides, paint or hair chemicals?	N-O	Y-2	S-1	1-4	1 capsule - 2x/day - with meals
Family history of cancer?	N-O	Y-2	S-1	5-8	2 capsules - 2x/day - with meals
Do you bruise easily?	N-O	Y-2	S-1	9-15	2 capsules - 3x/day - with meals
Are you sensitive to chemicals or environmental pollution?	N-O	Y-2	S-1		
Do you have vision problems?	N-O	Y-2	S-1		
Total Score:_____					

Section 23 – TOTAL NUTRITION				**SCORE**	**RECOMMENDATIONS**
Do you enjoy meal replacement shakes?	N-O	Y-2	S-1		
Do you work out on a regular basis?	N-O	Y-2	S-1	1-4	1 scoop - 1x/day as a meal
Are you looking for healthy protein sources?	N-O	Y-2	S-1	5-6	2 scoops - 1x/day as a meal
Are you an extreme athlete?	N-O	Y-2	S-1	7-8	2 scoops - 2x/day as a meal
Total Score:_____					

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- Thomas Edison