

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 (**please be honest**)? Check all that apply:
 - 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?) _____

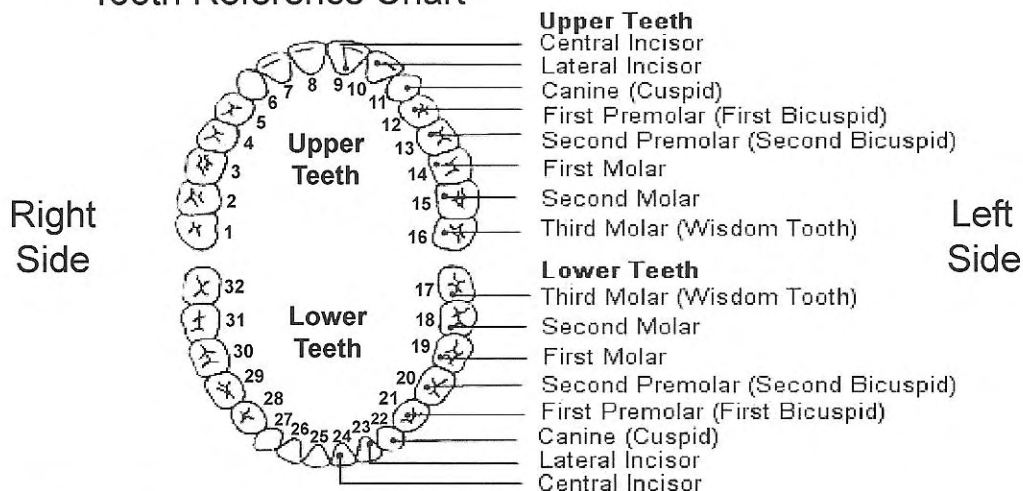
8. How far are you willing to commit to achieve your health goals? (**Please be honest.**)
 - don't really want to change much
 - willing to change some
 - willing to change a reasonable amount
 - willing to do whatever it takes
9. How much money do you spend per month on your health, out of pocket? _____
10. How long do you want to live? (Check all that apply.)

<input type="checkbox"/> age 60-70	<input type="checkbox"/> as long as I'm healthy
<input type="checkbox"/> age 70-80	<input type="checkbox"/> as long as I have been granted
<input type="checkbox"/> age 80-90	<input type="checkbox"/> until I complete my mission (purpose) on earth
<input type="checkbox"/> age 90 - 100	<input type="checkbox"/> only if my significant other is still alive also
<input type="checkbox"/> age 100+	<input type="checkbox"/> forever
	<input type="checkbox"/> it's already enough

Dental History Chart

Name: _____ Date: _____

Tooth Reference Chart

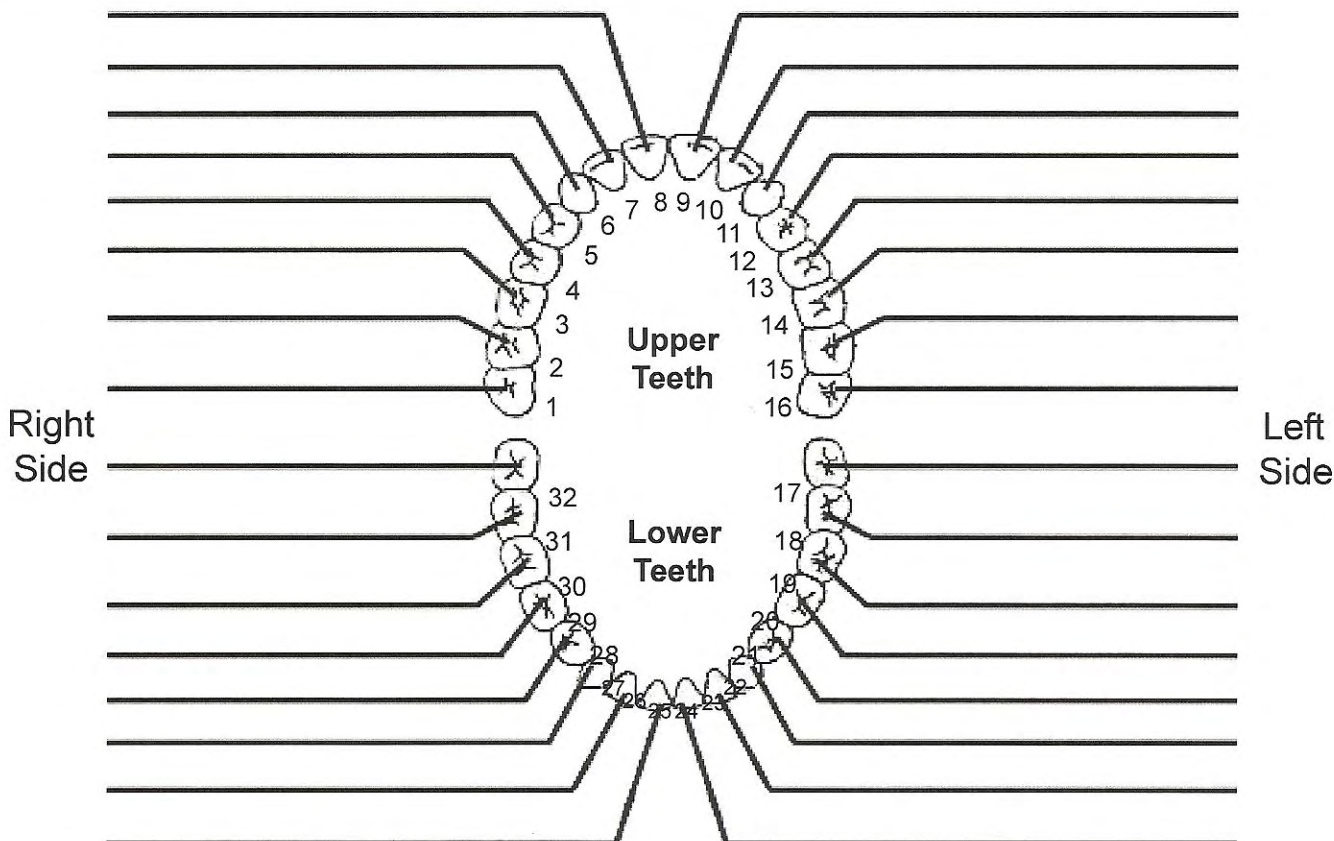


Directions: Please fill in the Dental History Chart below by writing down what was done to each tooth and the approximate age it was done. For an extracted tooth, put an X over the tooth. For example, on the line for left lower second molar, you might write: "Silver filling, age 22." **Please see Example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

Please use the following descriptors when filling in the chart:

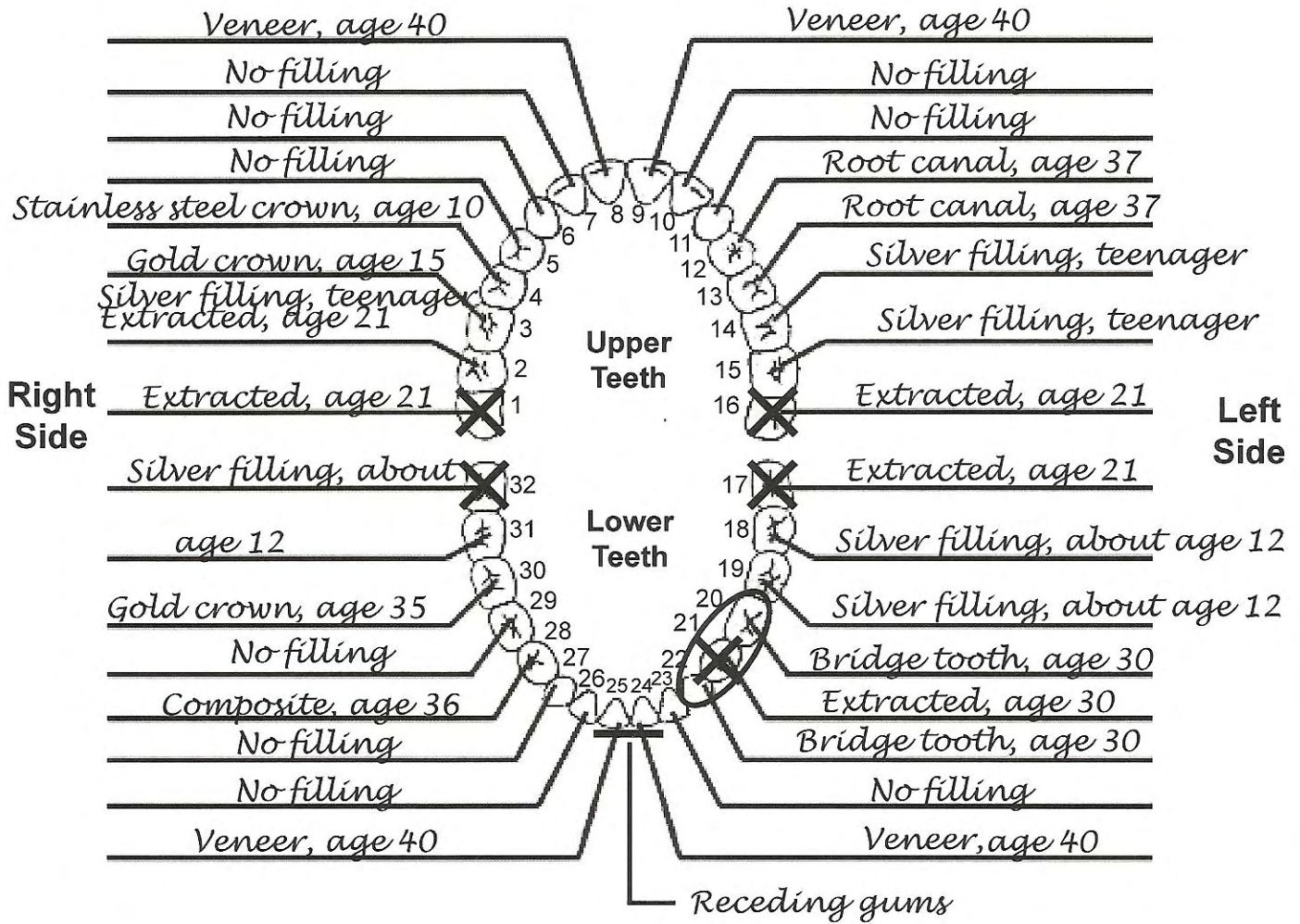
- | | | | |
|--|-------------------------|--|---|
| ◆ Silver filling | ◆ Stainless steel crown | ◆ Bridge (circle teeth with bridge attached) | ◆ Full denture |
| ◆ Composite filling (plastic-like filling) | ◆ Root canal | ◆ Partial denture | ◆ Extracted tooth (write next to X'd out tooth) |
| ◆ Gold crown | ◆ Post (in root canal) | ◆ Veneers | ◆ 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

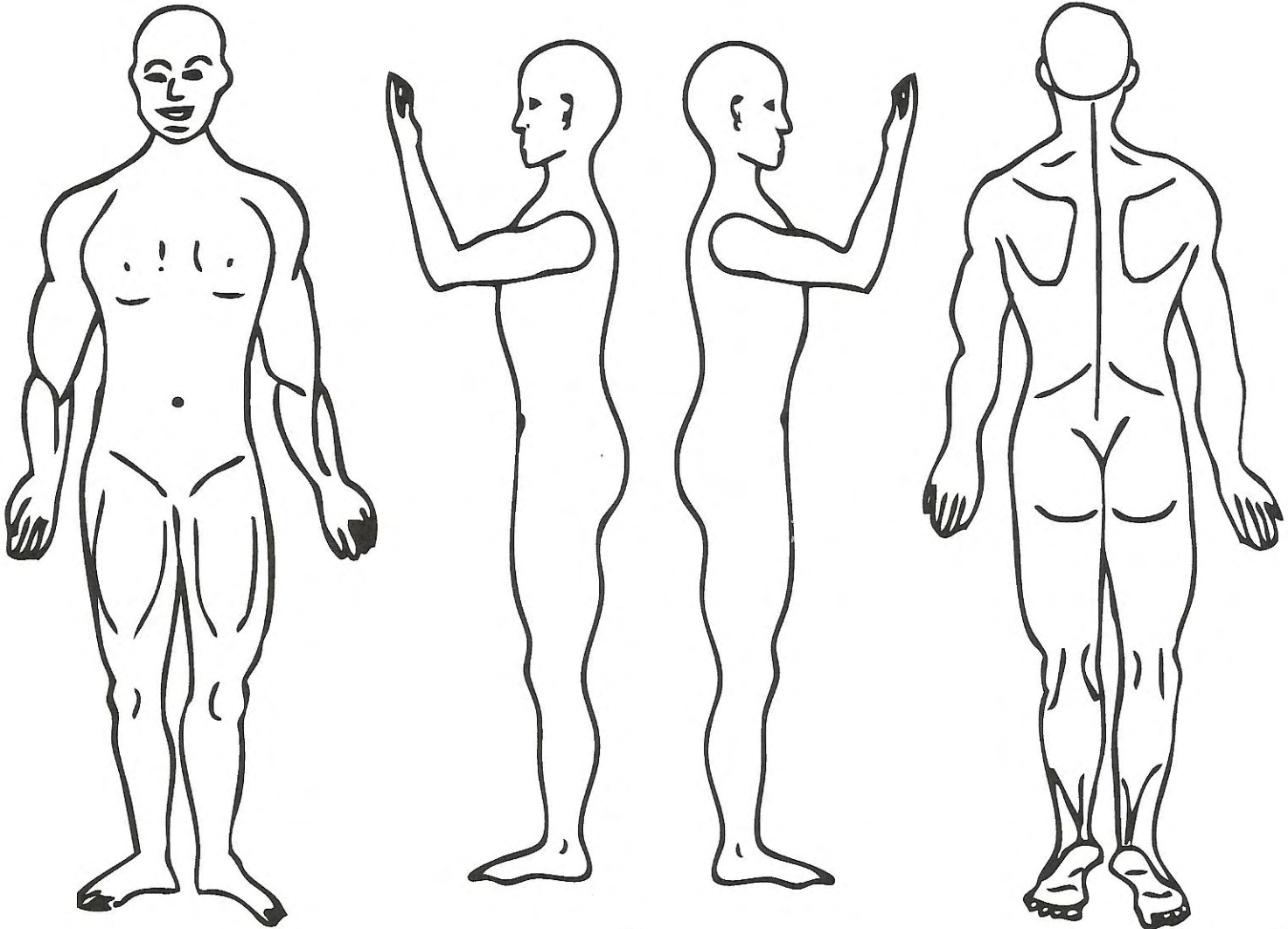
Name: Den Tall Date: 4-10-07



Scar/Trauma Chart

Name: _____

Date: _____



Directions

All Scars. 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.

All Trauma Areas. 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.

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

Date of injury and type of injury. 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.")

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