Weekend Detox & Weight Loss Cleanse

with Dr. Tom Francescott

May 31-June 2, 2013

Weekend Detox Intake Form

Your time, thoughtfulness, and honesty are greatly appreciated.

Thank-you for your interest in this detox & wellness retreat. Please complete this form, even if you have submitted one for previous programs. The nature of your responses to the following questions will go a long way in assisting my understanding of your life & health, and will help me tailor the week to your specific needs.

Please read the forms carefully, sign, and return them as soon as possible by:

Mail:
Omega Institute for Holistic Studies
Attn: Registration Dept
150 Lake Drive
Rhinebeck, NY 12572

Or scan and email:
classapplications@eOmega.org

Please note that because our cleansing program is educational & experiential in nature, it is not intended as therapy for serious illness, nor a substitution for primary medical care.

Please Note: If you consume caffeine, nicotine, and/or artificial sweeteners regularly, I highly recommend that you reduce and/or wean yourself off them the week before you come, *if possible.*

GENERAL INFORMATION

Name:____

Address:____

City:____________________________

State:__________Zip:______________

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Phone: Home:_____________________Cell: _________________________

Email Address:____

Website:____

Occupation_____________________________________

Hours per week________ Retired___________________

Date of birth:_________Age: ______Blood Type:_______

Height___________ Weight________________________

Person to notify in case of

emergency:____________________________Phone:__________________

Has any other family member already been a

patient _______________________________

or attended a workshop of Dr. Tom? _____________________________

___Married___Partnership____Separated___Divorced____Widowed___Single

Live with:___Spouse___Partner___Parents ___Children ___Friends ____Alone

Do you have any children? Yes No How many? _______

Their names/ages:____

Health care practitioners you are currently

seeing?____

____

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____Have you ever consulted with a Naturopathic Physician before? Yes No

Who?____

Date of last complete physical exam: ______________________________

Date of last blood tests:____

Are you allergic to any drugs, chemicals, animals, environmental substances? ______Yes______No

If yes, please list:____

What happens when you have an "allergy attack"?____

BACKGROUND INFORMATION

What is the primary reason for your interest in this retreat?

____

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What would you like to accomplish with this program?

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What are your most important health concerns at this time?

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How did these issues/conditions develop?

Are there any traumatic events that you can identify as having caused or clearly aggravated your health challenges? What happened in your life around this time? Do you know anything about your birth process? If you prefer, list these in order of occurrence on a separate page

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Please list any prescriptions, medications, and supplements which you are *presently taking and why?*

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Have you ever undertaken a cleanse before? _____yes _____no

If yes, for how long?____

If yes, briefly describe the type of

cleanse____

Are you having regular bowel movements? _____yes ______ no

How many per day?_________ Well formed? ______________________

Easily eliminated? ____

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How would you rate your energy level? excellent good mediocre poor

How is your sleep? *fall asleep easily? stay asleep throughout night? wake feeling refreshed?*____

How would you rate your mood? ___excellent ___good ____average____poor

How would you rate your pain level? 0 (none) to 10 (extreme)____________

DIET:

How is your appetite? ____extreme ____strong ____good ___lacking

What do you crave? _____carbs ____sugar _____salt _____meat ____ choc

other?____

How many meals do you generally eat each day? ___1 ___2 ____3 ____3+

Do you: ___eat out often ___diet frequently ___skip meals frequently

Do you have any special diet or eating restrictions? ____Yes ___No

if yes, please explain____

List the primary foods you include in your diet

____

List the foods you exclude from your diet at this time____

Do you have any food sensitivities that you are aware of? ______no _____yes

If yes, what foods?____

Do you currently experience food binges? ______no ______yes

If yes, what are the trigger foods?___________________________________

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Are you currently using coffee, diet sodas, or nicotine? _____no ______ yes

If yes, how much daily?____

Mark those that you consume regularly. ____Caffeinated teas ___Artificial sweeteners ____Processed foods ____Preservatives ____Refined foods___Margarine ___Trans-fatty acids ____Sugar/sweets

PAST MEDICAL HISTORY

YOUR PRENATAL/BIRTH PROCESS:

Any known problems/birth trauma during your mother's pregnancy with you:____

C-section?________ Umbilical cord problems?_______forceps used?_______

Antibiotics?________ Breast fed?________ how long?______ Formula (kind):________________________how long?_______

Age solid foods began:_________

What foods were eaten in your first year of life__________________________

PERSONAL:

Major accidents/traumas (with dates):_________________________________

Severe stresses/emotional traumas:____

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Are you happy in your job or career? ____Yes ____No

____

____ What personal goals do you have?_________________________________

What makes you happy?____ What are you grateful for?____ What is your individual & unique purpose in this life?____Religious /spiritual affiliation______________________________________

What would you like to change most about your life?____ What behaviors, habits, or thoughts would you like to eliminate?____

Is your present sex life satisfactory? _________________________________