Detox & Weight Loss Cleanse

with Dr. Tom Francescott

May 31-June 7, 2013

7-Day 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?

_____

_____

_____

_____

What would you like to accomplish with this program?

_____

_____

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What are your most important health concerns at this time?

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?*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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? _____