

**Transformational Cleansing™: Healing for Body & Soul**  
**2-Day Weekend Retreat**  
with Dr. Tom Francescotti  
May 19-21, 2017

**Detox Health 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:  
Registration Dept  
Omega Institute for Holistic Studies  
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.*

*Also, 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: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation \_\_\_\_\_

Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

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Height\_\_\_\_\_ Weight\_\_\_\_\_

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? \_\_\_\_\_

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

**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? \_\_\_\_\_

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?\_\_\_\_\_

Are you currently using coffee, diet sodas, or nicotine? \_\_\_no \_\_\_yes

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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? \_\_\_\_\_

What would you like to change most about your  
life? \_\_\_\_\_

—

What behaviors, habits, or thoughts would you like to  
eliminate? \_\_\_\_\_

\_\_\_\_\_