

Transformational Cleansing™: A Guided Detox Experience
7-Day Weeklong Retreat
with Dr. Tom Francescotti
May 11-18, 2018

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:
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.

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?

What would you like to accomplish with this program?

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

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? _____

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

If yes, how much

daily?_____

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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: _____

Are you happy in your job or career? Yes No

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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? _____
