



Detroit Wholistic Center

Personal Health Evaluation Cleansing and Rebuilding Program

Name	Home Phone	Cell Phone	Start Date

Note: If you are taking medication consider consulting your doctor regardless of taking these products. Always check product ingredients if you have food or other allergies.

To start indicate in the first column which of the following condition apply to you in the terms of frequency and/or intensity using √, √√, √√√. This exercise will help you recall how you felt prior to starting the program and enable you to measure your progress.

Condition	Present	14 Days	30 Days	60 Days	90 Days
Low Energy/ Off Feel Tired					
Skin Problems-Dry, Itchy, Acne					
Headaches/Migraines					
Cuts & Bruising Heal Slowly					
Aching Joints					
Muscle Cramps					
Menstrual Cramps/Moody/PMS					
Difficulty Handling Stress					
Subject to Colds & Infections					
Poor Concentration					
Strong Desire for Sweets/Salts					
High/Low Blood Pressure					
Frequently Take Pain Killers					
Moods of Depression					
Difficulty Getting Up in Morning					
Difficulty Falling Asleep					
Cold Hands & Feet					
Shortness of Breath					
Often Feeling Bloating					
Bowel Gas					
Heartburn/Indigestion					
Constipation/Diarrhea					
Weak Fingernails/Unhealthy Hair					
Poor Muscle Tone					
Water Retention					
Cellulite					
Allergies/Hay Fever					
Poor Night Vision					
Hemorrhoids					
Varicose Veins					

How many glasses of water do you drink each day? 1 ___ 2 ___ 3 ___ 4 ___ 5 ___ 6 ___ 7 ___ 8 ___

Do you consume coffee, tea, or pop daily? _____ How many servings daily? _____

Do you wish to lose weight? _____ Or gain weight? _____ If so, how much? _____

Are you on any medication? _____ Type: _____ Reason? _____

Number of meals each day? _____ Number of bowel movements each day? _____ Or week? _____

Do you have any particular health problems? _____

Neck in. _____ Chest in. _____ Waist in. _____ Weight lbs./ kg. _____ Age. _____