The DCP-DETOX

Detox, Size and Weight Loss Screening Form 2011

Name		Cell Phone	
E-mail		Home Tel.	
Address		Referred By	

Typical Meals	Times	What do you Eat?	Comments
Breakfast			
Lunch			
Dinner			
Snacks and Indulgences			

PERSONAL	Data	Do you Consume the Following?				Type No's
Age		1. Sugar	2.Tea	3. Coffee	4. Red Meat	
Present Weight		5. Cokes	6. Milk	7. Grains	8. Fish	
Height		9. Chicken	10.Fruit	11. Veg	12. Seeds	
Target Weight		13. Nuts	14.Herbs	15. Spices	16. Vitamins	

WEIGHT		DIGESTIVE TRACT	DATA
Binge Eating		Heartburn	
Crave Certain Foods		Diarrhea	
Excessive Weight		Constipation	
Compulsive Eating		Bloated Feeling	
Water Retention		Burping or Passing Gas	
Skip Meals Often		Intestinal Pain	
Excess Alcohol		Diagnosed Digestive Disorders? –Ulcers	
Night Eating (After 8pm)		Bad Breath or Foul Smelling Stools?	
		Is your Digestion sensitive to HOT, Spicy Foods?	
ENERGY/ACTIVITY		Are you Stressed?	
Fatigue-Sluggish		Allergies?	
Apathy-Lethargy		Occupation?	
Hyperactivity		IMPORTANT.....PLEASE ANSWER ACCURATELY!	
Restlessness		How Much WATER do you consume Daily?	
EMOTIONS		How many hours of Sleep do you get daily?	
Mood Swings		Do you Exercise?	
Anxiety, Fear		Are you a Victim of your Own Self-Neglect?	
Anger, Irritable		Do you Smoke Cigarettes? How many daily?	
Depression		When last have you had a Medical Check-Up?	
Emotional Eater			
		AFFLICTIONS	
SKIN		Diabetes?	
Acne, Hives, Rashes		Hypertension?	
Hair Loss		Thrombosis? Varicose Veins?	
Excessive Sweating		Arthritis? Cardiovascular Complications?	
LUNGS		State here. What have you been diagnosed with?	
Chest Congestion		Other	
Asthma, Bronchitis		Other	

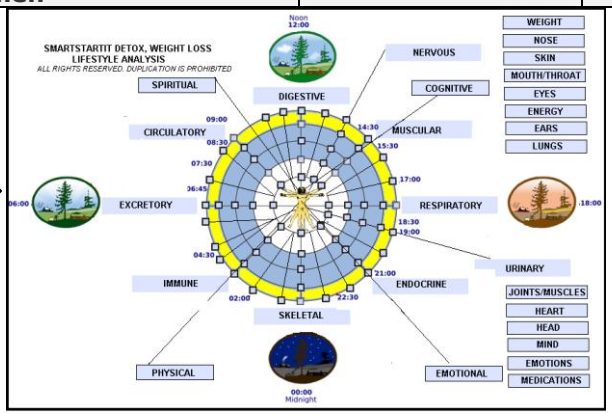
Short of Breadth		**Please let us know how you are FEELING**	**Office Use**
Difficulty Breathing		**physically and emotionally**	**Fatigue**
HEAD			**Constipation**
Headaches			**Digestive**
Faintness			**Gastritis**
Insomnia			**Respiration**
Dizziness			**AC-ALK**
HEART			**Excess W**
Irregular Heart Beat			**Eczema**
Rapid and Pounding Heartbeat			**Cholesterol Arthritis**
Chest Pain			**Aging**
		Total Program Price	**R**
		Less: Amount for Screening	**R**
		Total amount owing	**R**

Messages from your Body. Please tick and Comment

Date

Indigestion or Incomplete Digestion		
Bloating		
Abdominal Pain/Cramps		
Low Back Pain		
Bladder/urination problems		
Varicose Veins		
Water Retention		
Bad Breadth		
Ear Infections		
Frequent Sore Throat		
Dandruff		
Dry/Oily Hair		
Soft or Brittle Nails		
Dry/Oily Skin		
Sensitive to Perfumes		
Body Aches and Pains		
Hemorrhoids /Protruding Rectum		
Pain/Swelling or Lumps		
Painful Menstruation		
Anal Itching		
Sensitive Mouth/Gums		
Hiatus Hernia		
Low attention Span		
Foggy Head		
Swollen Abdomen		

Office Use



Important
Rhythm and Times
Please Fill in this Section.

Daily Activity	Typical Time	Office Use
Wake Up		
Breakfast		
Commute		
Start Work		
Lunch		
End Work		
Exercise		
Dinner		
Bedtime		
Tummy Works		
Other		

Please read through carefully:

1. Please do not take offence if we advise you to see your Medical Doctor to address your PAIN and DISCOMFORT.

2. Please acknowledge that this Program only uses Fruits, Vegetables, Herbs and Natural Products. There are no inorganic chemicals, preservatives or colorants used in this Program.

3. All Eating Plans supplied exclude ALL PROCESSED FOODS.

Signature:_____

Date:_____