CLIENT INFORMATION

NAME: _____ **EMAIL ADDRESS*** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

BIRTHDATE: _____ **AGE:** _____ **Drivers License or SS#:** _____ **HEIGHT/WEIGHT:** _____/_____

OCCUPATION: _____ **REFERRED BY:** _____

What are your present symptoms and/or complaints?

Any current medications? Reasons for medication:

Describe any previous treatments and/or surgeries relating to your present complaints:

Describe any significant family medical history:

Are you allergic to alcohol? Yes____ No_____ Any other allergies? Yes_____ No_____

Any other pertinent information?

Do you want this office to consult any other health practitioner you are seeing? Yes ____ No ____

Name: _____ **Phone Number:** _____

Why consulted: _____

IMPORTANT: Remember to include this sheet and a $170 deposit check with samples. Any remaining balance will be invoiced. We accept Visa and Master Card for your convenience. If you wish to pay with a credit card we can charge the entire invoice immediately following the completion of your evaluation.

Acct. #_____ Exp. Date_____
Name (as it appears on card)_____
I would like to have my credit card kept on file to pay for services and products: Yes ____/No____
Authorized Signature: _____

Please Note!: Re-Evaluation is recommended 3-4 weeks after your initial Bio-Evaluation.

*by providing us your email address you agree to receive information and offers from us. Your Email address will be kept confidential.

OVER …

Rate each of the following symptoms based upon your health profile for the past 30 days. Add up the numbers to arrive at a total for each section, then add the totals for each section to arrive at the grand total.

POINT SCALE:

0 = never or almost never have the symptom
1 = occasionally have it, effect is not severe
2 = occasionally have it, effect is severe
3= frequently have it, effect is not severe
4 = frequently have it, effect is severe

DIGESTIVE
__Nausea or vomiting
__Diarrhea
__Constipation
__Belching, passing gas
__Heartburn
__TOTAL

EARS
__Itchy Ears
__Earaches, ear infection
__Drainage from ear
__Ringing in ears, hearing loss
__TOTAL

EMOTIONS
__Mood swings
__Anxiety, fear, nervousness
__Anger, irritability
__Hyperactivity
__Restlessness
__TOTAL

ENERGY / ACTIVITY
__Fatigue, sluggishness
__Apathy, lethargy
__Hyperactivity
__Restlessness
__TOTAL

EYES
__Watery, itchy eyes
__Swollen, reddened or sticky eyelids
__Dark circles under eyes
__Blurred / tunnel vision
__TOTAL

HEART
__Skipped heartbeats
__Rapid heartbeats
__Chest pain
__TOTAL

HEAD
__Headaches
__Faintness
__Dizziness
__Insomnia
__TOTAL

LUNGS
__Chest congestion
__Asthma, bronchitis
__Shortness of breath
__Difficulty breathing
__TOTAL

MIND
__Poor memory
__Confusion
__Poor concentration
__Poor coordination
__Difficulty making decisions
__Stuttering, stammering
__Slurred speech
__Learning Disabilities
__TOTAL

MOUTH / THROAT
__Chronic coughing
__Gagging, frequent need to clear throat
__Sore throat, hoarse
__Swollen or discolored tongue, gums, lips
__Canker sores
__TOTAL

NOSE
__Stuffy nose
__Sinus problems
__Hay fever
__Sneezing attacks
__Excessive mucus
__TOTAL

SKIN
__Acne
__Hives, rash, dry skin
__Hair loss
__Flushing or hot flashes
__Excessive sweating
__TOTAL

JOINTS / MUSCLES
__Pain or aches in joints
__Arthritis
__Stiffness, limited movement
__Pain, aches in muscles
__feeling of weakness or tiredness
__TOTAL

WEIGHT
__Binge eating/drinking
__Craving certain foods
__Excessive weight
__Compulsive eating
__Water retention
__Underweight
__TOTAL

OTHER
__Frequent illness
__Frequent or urgent urination
__Genital itch, discharge
__Breast tenderness, discharge, lumps
__Testicle tenderness, swelling
__TOTAL

__ GRAND TOTAL