Polly Heil-Mealey, ND, M Ed., CCI

www.pollyheilmealey.com
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Phone: (281) 312-2860
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Client Intake Form

The practice of Iridology/EAV requires the understanding of clients as a whole: mind, body and spirit. Please take the time to fill out this intake form as completely as possible. This form will provide a foundation for your experience at the office, as it will help to simulate areas that may need special attention during your visit.

Name: _____ Date: _____

Street Address/P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ ☐ Male ☐ Female Height: _____ Weight: _____

Referral Source: _____ ☐Self

Primary Care Physician: _____

Goals: Please list the reasons you are seeking an Iridology evaluation.

_____
_____
_____
_____
_____

Past Medical History: Check all that apply and fill in any not listed at the end.

☐Allergies	☐Diabetes	☐Kidney Disease
☐Alzheimer's	☐Diarrhea	☐Low Testosterone
☐Anemia	☐Diverticulitis	☐Menopause
☐Anxiety	☐Eczema	☐Migraines
☐Arthritis	☐Emphysema	☐Multiple Sclerosis
☐Asthma	☐Endometriosis	☐Osteoporosis
☐Bleeding Disorder	☐Fibromyalgia	☐Panic Disorder
☐Blood clots	☐Gout	☐Prostate Enlargement
☐Breast Disease	☐Heart Disease	☐Reflux (GERD)
☐Broken Bone	☐Hepatitis	☐Seizures
☐Cancer–Type:_____	☐High Blood Pressure	☐Stroke
☐Chronic Fatigue	☐High Cholesterol	☐Urinary Tract Infection
☐Chronic Pain-Where:____	☐Hypothyroidism	☐_____
☐Chronic Sinusitis	☐Impotence	☐_____
☐Depression	☐Irritable Bowels	☐_____

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Past Surgical History: List year performed next to surgery. Fill in those not listed at the end.

☐Appendix _____
☐Gall Bladder _____
☐Tonsils _____
☐Tubes in Ears _____
☐Hysterectomy _____
Check one: ☐Partial ☐Total

☐Tubal Ligation _____
☐Cardiac Bypass _____
☐Catheterization_____
☐Spinal Fusion_____
☐Joint Replacement _____
☐Which joint: _____

☐_____
☐_____
☐_____
☐_____
☐_____
☐_____

Review of Current Symptoms: Please check any symptoms or concerns you have had in the last several months.

Constitutional
☐Good general health
☐Recent weight change
☐Headaches
☐Fever

Ears/Nose/Throat
☐Hearing loss or ringing
☐Earaches or drainage
☐Sinus problems
☐Nosebleeds
☐Bad breath or bad taste
☐Sore throat or voice change
☐Swollen glands in neck

Eyes
☐Eye disease or injury
☐Wear glasses/contacts
☐Glaucoma
☐Double/blurred vision

Cardiovascular
☐Chest pain or pressure
☐Palpitations
☐Shortness of breath lying flat
☐Swelling of extremities

Respiratory
☐Chronic or frequent cough
☐Shortness of breath
☐Asthma or wheezing

Energy
☐Forgetful
☐Poor concentration
☐Fatigue – worst time of day:

Gastrointestinal
☐Loss of appetite
☐Nausea or vomiting
☐Diarrhea
☐Painful bowel movement
☐Constipation
☐Rectal bleeding
☐Abdominal pain

Hematology
☐Bleeding or bruising
☐Anemia
☐Past transfusion

Genitourinary
☐Frequent urination
☐Painful urination
☐Blood in urine
☐Change in force of urine
☐Incontinence
☐Kidney stones
☐ Male – testicle pain
☐ Female – irregular menses

Neurological
☐Frequent headaches
☐Light-headed/dizzy
☐Convulsions
☐Numbness/tingling
☐Tremors
☐Head injury

Musculoskeletal
☐Joint pain
☐Joint stiffness/swelling
☐Weak muscles or joints
☐Muscle pain or cramps
☐Back pain
☐Difficulty in walking

Skin/Breast
☐Cold hands or feet
☐Hives
☐Rash or itching
☐Hair loss
☐Varicose veins
☐Breast pain
☐Breast lump

Psychiatric
☐Memory loss/confusion
☐Nervousness/anxiety
☐Depression/mania
☐Addictive behavior

Endocrine
☐Excessive thirst/urination
☐Sugar cravings
☐Hot/cold intolerance
☐Poor sex drive
☐Dry skin

Sleep
☐Problems falling asleep
☐Problems staying asleep
☐Snore
☐Restless legs

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Family Medical History: To the best of your knowledge, have any blood relatives been diagnosed with the Following? (Please state the family member(s) relationship in the space provided):

☐Alcoholism _____
☐Allergies _____
☐Alzheimer's _____
☐Anemia _____
☐Asthma _____
☐Birth Defect _____
☐Bleeding Disorder _____
☐Cancer:
Member/Type: _____
Member/Type: _____
Member/Type: _____

☐Depression _____
☐Diabetes_____
☐Epilepsy _____
☐Heart Disease _____
☐High Blood Pressure_____
☐High Cholesterol _____
☐Kidney Disease _____
☐Stroke _____
_____
_____
_____

Allergies

Do you have any drug allergies? ☐Yes ☐No

If yes, please list the drugs and the reaction you had:_____

_____

_____

Environmental allergies? ☐Yes ☐No

_____

_____

Food allergies? ☐Yes ☐No

_____

_____

Social History

Number of children: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Other

Occupation: Please list what you do, approximately how many hours you work per week and your level of satisfaction with your job: _____

_____

Has this or any job put you around strong chemicals or smoke? ☐Yes ☐No

Tobacco use: ☐Yes ☐No If yes, how many per day: _____ How many years: _____

Currently smoking: ☐Yes ☐No If you quit, how long ago: _____

Smoke exposure at home: ☐Yes ☐No

Alcohol use: ☐Yes ☐No If yes, how many drinks per week: _____ How many years: _____

Drug use (state which drug and if currently using): _____

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Medications and Supplements: Please list all medications and supplements you are currently taking:_____
_____
_____
_____

Stress: Stress and the management of stress is very important to you overall health.
Describe your recreation activities:

_____
_____

Describe your relaxation activities:

_____
_____

You are happiest when:

_____
_____

Spiritual Life: Having an active spiritual life is an important part of your overall health. Describe your current religious practice. (Please provide details as to how often and what you do. For example, do you attend church or other ceremonies? Any small group study?):

_____
_____

Previous Complimentary Medicine Experiences:

☐Acupuncture	☐Homeopathy	☐Naturopathy
☐Biofeedback	☐Hypnotherapy	☐Reflexology
☐Chiropractic	☐Iridology	☐Relki
☐Guided Imagery	☐Massage	☐Psychological Counseling
☐Healing Touch	☐Meditation	☐Yoga

Additional Dietary Information: Please provide honest answers to these questions based usage on a typical day.

Cups of regular coffee: _____
Cups of decaf coffee: _____
Cups of regular tea: _____
Cups of decaf tea: _____
Regular soda: _____
Diet soda: _____

Crystal Light: _____
Artificial Sweetener packs (Splenda or others):
_____
Flavored water or Propel: _____
Meals per day: _____
Meals made at home: _____

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Exercise: Please answer questions based on an average week.

How many times per week do you exercise? _____

List the specific exercises that you do, and how long you typically do them:

Exercise	**Duration**
_____	_____
_____	_____
_____	_____
_____	_____

Preventative Services: Please list the date of your most recent screening procedures:

Breast Cancer: Mammogram _____

Cervical Cancer: Pap Smear_____

Colposcopy _____

Colon Cancer: Colonoscopy _____

Three stool test _____

Prostate Cancer: PSA _____

Digital Rectal Exam _____

Diabetes: Fasting blood sugar _____

Heart Disease: Fasting lipid panel_____

Osteoporosis: DEXA scan_____

Carotid Artery Disease: Carotid Doppler _____

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I _____fully understand that P. Heil-Mealey, ND, CCI, M Ed., and is not a Medical Doctor, nor Medical Practitioner, and I attest that I am not here for medical diagnostic or treatment procedures.

Further, I have been advised that if I have a medical problem, I should seek the advice of a licensed Medical Doctor for my state of condition.

The services performed by P. Heil-Mealey are at all times restricted to consultation on the subject of nutritional matters, and do not involve the diagnosing, prognosticating, treatment or prescribing of remedies for treatment of condition or disease, or any act which will constitute the practice of medicine in this state.

Member Share
Member Share Agreement (MSA)
Member Share is a name given the membership program of the Pastoral Medical Association TM, a private ecclesiastical association and tribunal with a mission to further a more natural form of health care and to do so in-part by providing members with a constitutionally protected private gathering place to exercise the desires and rights specified herein.

I understand that members of the Association come together to help each other achieve better health and live longer with good quality of life, and that members accept the goals of helping their body function better and choosing options that are both very safe and have a reasonably good chance to succeed, realizing that no diagnostic technique is foolproof.

I understand that members have freely chosen to change their legal status as a public person and/or patient, to a private member of the Association. With my signature I agree that all of my questions have been answered fully to my satisfaction and with these understandings, I wish to become a member and herby request and agree to join the Association.

In Witness Whereof I set my hand this _____ day of _____, 20____

*Printed Name:(Please print legibly)*_____

*Signature:*_____

*Legal Guardian Signature: (if client under 18 years of age)*_____

*Date:*_____