



## 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: \_\_\_\_\_

Are you a Veteran?  YES  NO

Referral Source: \_\_\_\_\_  Self

Primary Care Physician: \_\_\_\_\_

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

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

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

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

- |  |  |                                |
|--|--|--------------------------------|
| <input type="checkbox"/> Appendix _____                                    | <input type="checkbox"/> Tubal Ligation _____    | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gall Bladder _____                                | <input type="checkbox"/> Cardiac Bypass _____    | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tonsils _____                                     | <input type="checkbox"/> Catheterization _____   | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Tubes in Ears _____                               | <input type="checkbox"/> Spinal Fusion _____     | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hysterectomy _____                                | <input type="checkbox"/> Joint Replacement _____ | <input type="checkbox"/> _____ |
| Check one: <input type="checkbox"/> Partial <input type="checkbox"/> Total | <input type="checkbox"/> Which joint: _____      | <input type="checkbox"/> _____ |

**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

**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):

- |  |  |
|--|--|
| <input type="checkbox"/> Alcoholism _____        | <input type="checkbox"/> Depression _____          |
| <input type="checkbox"/> Allergies _____         | <input type="checkbox"/> Diabetes _____            |
| <input type="checkbox"/> Alzheimer's _____       | <input type="checkbox"/> Epilepsy _____            |
| <input type="checkbox"/> Anemia _____            | <input type="checkbox"/> Heart Disease _____       |
| <input type="checkbox"/> Asthma _____            | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Birth Defect _____      | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Bleeding Disorder _____ | <input type="checkbox"/> Kidney Disease _____      |
| <input type="checkbox"/> Cancer:                 | <input type="checkbox"/> Stroke _____              |
| Member/Type: _____                               | _____  |
| Member/Type: _____                               | _____  |
| Member/Type: _____                               | _____  |

**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): \_\_\_\_\_

**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:**

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Acupuncture    | <input type="checkbox"/> Homeopathy   | <input type="checkbox"/> Naturopathy              |
| <input type="checkbox"/> Biofeedback    | <input type="checkbox"/> Hypnotherapy | <input type="checkbox"/> Reflexology              |
| <input type="checkbox"/> Chiropractic   | <input type="checkbox"/> Iridology    | <input type="checkbox"/> Reiki                    |
| <input type="checkbox"/> Guided Imagery | <input type="checkbox"/> Massage      | <input type="checkbox"/> Psychological Counseling |
| <input type="checkbox"/> Healing Touch  | <input type="checkbox"/> Meditation   | <input type="checkbox"/> 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: \_\_\_\_\_

**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 \_\_\_\_\_

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.

As members we declare the right to select other members of the Association to give us counsel and advice for our physical, mental and spiritual health, and to request member assistance in facilitating for us the actual performance and delivery of the therapies, treatments and care we so choose for ourselves and our families.

As members we proclaim the freedom to select for ourselves the types of health care we think best for treating and preventing illness and disease of our minds and bodies, including but not limited to any and all treatment modalities and therapies practiced or used by any type of healers, therapists or practitioners the world over, whether conventional or unconventional.

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 hereby 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:\_\_\_\_\_

## BioEnergetic Health Survey

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M/F \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions: Indicate the symptoms which apply to you using the following scale:**

(0) if "never"      (1) if "rarely"      (2) if "time to time"      (3) if "often"

### DIGESTIVE

<input type="checkbox"/> Lower bowel gas several hours after eating	<input type="checkbox"/> Excessive belching/burping
<input type="checkbox"/> Burning stomach sensation, eating relieves	<input type="checkbox"/> Bad breath
<input type="checkbox"/> Coated tongue	<input type="checkbox"/> Alternating diarrhea/constipation
<input type="checkbox"/> Indigestion 1/2-1 hr after eating (may be up to 3/4 hrs)	<input type="checkbox"/> Have pet e.g. dogs, cats, farm animals etc.
<input type="checkbox"/> Carbonated drinks 3+ per week?	<input type="checkbox"/> Rectal itching
<input type="checkbox"/> Difficult bowel movements	<input type="checkbox"/> Can't gain weight
<input type="checkbox"/> Ulcers? Colitis? Gastritis?	<input type="checkbox"/> International travel
<input type="checkbox"/> Stomach bloating after eating	<input type="checkbox"/> Stomach/intestinal cramping/diarrhea
<b>Total: _____</b>	

### SUGAR HANDLING PROBLEMS

<input type="checkbox"/> Afternoon headaches	<input type="checkbox"/> Abnormal craving for sweets or snacks
<input type="checkbox"/> Get "shaky" if hungry	<input type="checkbox"/> Thirsty much of the time
<input type="checkbox"/> Faintness if meals delayed	<input type="checkbox"/> History of diabetes
<input type="checkbox"/> Heart palpitates if meals missed or delayed	<input type="checkbox"/> Excessive frequent urination
<input type="checkbox"/> Eat when nervous	<input type="checkbox"/> Blurred vision/failing eyesight
<input type="checkbox"/> Awaken after a few hours of sleep	<input type="checkbox"/> Breath smells sweet
<input type="checkbox"/> Hard to get back to sleep	<input type="checkbox"/> Tingling, numbness, prickling sensation in extremities
<input type="checkbox"/> Crave candy or coffee in the afternoon	
<b>Total: _____</b>	

### CARDIAC

<input type="checkbox"/> Bruise easily, "black & blue spots"	<input type="checkbox"/> Hands & feet go to sleep easily
<input type="checkbox"/> Sigh frequently	<input type="checkbox"/> Numbness in extremities
<input type="checkbox"/> Aware of "breathing heavily"	<input type="checkbox"/> Tendency to anemia
<input type="checkbox"/> Open window in closed room	<input type="checkbox"/> Tension under breastbone or feeling of tightness, worse during exertion
<input type="checkbox"/> Susceptible to colds & fevers	<input type="checkbox"/> Blushing with no apparent cause
<input type="checkbox"/> Swollen ankles, worse during night	<input type="checkbox"/> Black stool (no iron supplementation)
<input type="checkbox"/> Muscle cramps, worse during night	<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Shortness of breath on exertion	<input type="checkbox"/> Slurred speech
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Headaches
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Weakness/fatigue
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Out of breath frequently e.g., going up stairs
<input type="checkbox"/> Dull pain in chest or radiating into left arm, worse during exertion	<input type="checkbox"/> Nervousness
<b>Total: _____</b>	

**LIVER AND GALL BLADDER**

<input type="checkbox"/> Pain under right side of rib cage	<input type="checkbox"/> Laxatives used often
<input type="checkbox"/> Frequent skin rashes	<input type="checkbox"/> History of gall bladder attacks or gallstones
<input type="checkbox"/> Bitter metallic taste in mouth in morning	<input type="checkbox"/> History of hepatitis
<input type="checkbox"/> Bowel movements painful and difficult	<input type="checkbox"/> History of jaundice
<input type="checkbox"/> Low energy, weakness, exhaustion	<input type="checkbox"/> Sneezing attacks
<input type="checkbox"/> Upset from greasy/fatty foods	<input type="checkbox"/> Itchy skin, worse at night
<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Dry flaky skin, hair
<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> General feeling of poor health
<input type="checkbox"/> Stools light colored	<input type="checkbox"/> Aching muscles
<input type="checkbox"/> Pain between shoulder blades	<input type="checkbox"/> Swollen feet and/or legs
<b>Total: _____</b>	

**THYROID**

<input type="checkbox"/> Impaired hearing	<input type="checkbox"/> Slow pulse, below 65
<input type="checkbox"/> Decrease in appetite	<input type="checkbox"/> Cold hands and feet
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Gains weight easily
<input type="checkbox"/> Constipation	<input type="checkbox"/> Weight gain around hips
<input type="checkbox"/> Puffy hands/face	<input type="checkbox"/> Outer third of eyebrows thinning
<input type="checkbox"/> Tired/sluggish	<input type="checkbox"/> "Emotional"
<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Flush easily
<input type="checkbox"/> Infertility	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Mental sluggishness/forgetfulness	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Headache upon rising; wears off during day	
<b>Total: _____</b>	

**BONE DEVELOPMENT/MINERALS, ETC.**

<input type="checkbox"/> Hip & joint pain	<input type="checkbox"/> Bone loss/osteoporosis in family
<input type="checkbox"/> Receding gums and/or dental cavities	<input type="checkbox"/> Crunching, creaking joints
<input type="checkbox"/> Tendency towards slouching/weak	
<b>Total: _____</b>	

**ENVIRONMENTAL**

<input type="checkbox"/> Exposure to fumes e.g. paint, salon, car	<input type="checkbox"/> Skin disorders e.g., psoriasis, eczema etc
<input type="checkbox"/> Use pesticides in garden	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Live near power lines/high tension wires	<input type="checkbox"/> Hormone disorders
<input type="checkbox"/> Have mercury amalgams (silver) in mouth	<input type="checkbox"/> History of cancer/personal or familial
<b>Total: _____</b>	

**MUSCLE AND LIGAMENT**

<input type="checkbox"/> Muscle aches, stiffness, cramping and pains	<input type="checkbox"/> Fatigue, sluggishness
<input type="checkbox"/> Chiropractic adjustments don't hold	<input type="checkbox"/> Upper or lower back pain
<input type="checkbox"/> Whiplash and/or ligament trauma/strain	<input type="checkbox"/> Stiff neck and shoulders
<b>Total: _____</b>	



**ADRENAL**

<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Feeling unrefreshed upon awakening
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Allergies
<input type="checkbox"/> Low energy, lack of stamina	<input type="checkbox"/> Exhaustion--muscular and nervous
<input type="checkbox"/> General malaise, unhappiness	<input type="checkbox"/> Respiratory disorders
<input type="checkbox"/> Tendency to hives	<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Arthritic tendency	<input type="checkbox"/> Dizzy when stand up "too fast"
<input type="checkbox"/> Excessive perspiration	<input type="checkbox"/> Decreasing appetite
<input type="checkbox"/> Colds/flu often	<input type="checkbox"/> Irritable
<input type="checkbox"/> Weakness after illness	<input type="checkbox"/> Bright lights irritate
<input type="checkbox"/> Dark circles under the eyes	
<input type="checkbox"/> Crave salty foods	<b>Total: _____</b>

**FEMALE & MALE**

<b>Female Only</b>	<b>Male Only</b>
<input type="checkbox"/> Painful menses	<input type="checkbox"/> Tired too easily
<input type="checkbox"/> Premenstrual tension	<input type="checkbox"/> Urination difficult
<input type="checkbox"/> Very easily fatigued	<input type="checkbox"/> Pain on inside of legs or heel
<input type="checkbox"/> Depressed feeling	<input type="checkbox"/> Feeling of incomplete bowel evacuation
<input type="checkbox"/> Menstruation excessive and prolonged	<input type="checkbox"/> Prostrate trouble
<input type="checkbox"/> Painful breasts (monthly)	<input type="checkbox"/> Leg nervous at night
<input type="checkbox"/> Lumpy breasts/worst at menses	<input type="checkbox"/> Diminished sex drive
<input type="checkbox"/> Have taken birth control pills	
<input type="checkbox"/> Menopause, hot flashes, etc.	<b>Female Total: _____</b>
<input type="checkbox"/> Menses scanty or irregular	
<input type="checkbox"/> Acne, worse at menses	<b>Male Total: _____</b>
<input type="checkbox"/> Vaginal discharge/yeast, etc.	

**LUNG**

<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Bronchitis (frequent)
<input type="checkbox"/> Pain around ribs	<input type="checkbox"/> Infections settle in lungs
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Sensitive to smog
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Asthma
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Post nasal drip	<input type="checkbox"/> Smoker
<input type="checkbox"/> Sinus and nasal congestion	<input type="checkbox"/> Chronic lung congestion
<input type="checkbox"/> Coughing up phlegm	<input type="checkbox"/> Breathes through mouth
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Shallow breather
	<b>Total: _____</b>

**IMMUNE**

<input type="checkbox"/> Throat infections	<input type="checkbox"/> Cough with mucus
<input type="checkbox"/> Poor wound healing	<input type="checkbox"/> Swollen tongue
<input type="checkbox"/> Slow to recover from colds or flu	<input type="checkbox"/> Dark areas under the eyes/cheeks
<input type="checkbox"/> Gets boils or styes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Swollen lymph glands	<input type="checkbox"/> Post nasal drip
<input type="checkbox"/> Catch colds or flu easily	<input type="checkbox"/> Ear aches and infections
<input type="checkbox"/> Bumpy skin on arms	<input type="checkbox"/> Herpes/cold sores
<input type="checkbox"/> Inflamed or bleeding lungs	
<b>Total: _____</b>	

**KIDNEYS**

<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Strong smelling urine
<input type="checkbox"/> Rose-colored (bloody urine)	<input type="checkbox"/> Mild back pain
<input type="checkbox"/> Dripping after urination	<input type="checkbox"/> Interrupted urine stream
<input type="checkbox"/> Difficulty passing urine	<input type="checkbox"/> Tingling in joints
<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Joint and muscle pain/cramping
<input type="checkbox"/> Rarely need to urinate	<input type="checkbox"/> Can't hold urine
<input type="checkbox"/> Frequent bladder infections	<input type="checkbox"/> Dark circles under eyes
<input type="checkbox"/> Painful/burning when urinating	<input type="checkbox"/> Frequent urge to urinate but passes only small amounts
<input type="checkbox"/> Urination when cough or sneeze	
<b>Total: _____</b>	

How often do you take (or have taken) antibiotics? # _____ Y / N
Reactions to vaccinations Y / N
How many silver amalgams do you have in your mouth? _____ Root canals? _____ Crowns/bridges? Y / N
Were your wisdom teeth impacted? Y / N Other dental problems? Y / N
Allergies? Y / N (List main) _____
_____
Are you experiencing bone loss or osteoporosis? Y / N
Do you smoke? Y / N
Diagnosed for parasites? Y / N
Diagnosed history of Candida? Y / N
Exposure to pesticides Y / N
Drink 6-8 glasses of water daily Y / N
Hormone replacement medications Y / N