Dr. Polly Heil-Mealey, ND, D.PSc, HHP,

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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: _____

Are you a Veteran? ☐ YES ☐ NO

Referral Source: _____ ☐Self

Primary Care Physician: _____

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

_____
_____
_____
_____
_____

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

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

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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.

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 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:_____

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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

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

Total:_____

SUGAR HANDLING PROBLEMS

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

Total:_____

CARDIAC

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

Total:_____

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LIVER AND GALL BLADDER

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

THYROID

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

BONE DEVELOPMENT/MINERALS, ETC.

___ Hip & joint pain	___ Bone loss/osteoporosis in family
___ Receding gums and/or dental cavities	___ Crunching, creaking joints
___ Tendency towards slouching/weak	**Total:**_____

ENVIRONMENTAL

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

MUSCLE AND LIGAMENT

___ Muscle aches, stiffness, cramping and pains	___ Fatigue, sluggishness
___ Chiropractic adjustments don't hold	___ Upper or lower back pain
___ Whiplash and/or ligamental trauma/strain	___Stiff neck and shoulders
	Total:_____

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ADRENAL

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

Total:_____

FEMALE & MALE

Female Only

___ Painful menses
___ Premenstrual tension
___ Very easily fatigued
___ Depressed feeling
___ Menstruation excessive and prolonged
___ Painful breasts (monthly)
___ Lumpy breasts/worst at menses
___ Have taken birth control pills
___ Menopause, hot flashes, etc.
___ Menses scanty or irregular
___ Acne, worse at menses
___Vaginal discharge/yeast, etc.

Male Only

___ Tired too easily
___ Urination difficult
___ Pain on inside of legs or heel
___ Feeling of incomplete bowel evacuation
___ Prostrate trouble
___ Leg nervous at night
___ Diminished sex drive

Female Total:_____

Male Total:_____

LUNG

___ Chronic cough
___ Pain around ribs
___ Shortness of breath
___ Chest pain
___ Difficulty breathing
___ Post nasal drip
___ Sinus and nasal congestion
___ Coughing up phlegm
___ Coughing up blood
___ Bronchitis (frequent)
___ Infections settle in lungs
___ Sensitive to smog
___ Asthma
___ Wheezing
___ Smoker
___ Chronic lung congestion
___ Breathes through mouth
___ Shallow breather

Total:_____

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IMMUNE

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

Total:_____

KIDNEYS

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

Total:_____

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