

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 \$160 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