

## CLIENT RE-EVALUATION PROGRESS REPORT

NAME \_\_\_\_\_ Email address\* : \_\_\_\_\_

Date: \_\_\_\_\_ Date of last Bio-Evaluation: \_\_\_\_\_

Has your address, or phone number changed? No \_\_\_

Change to: \_\_\_\_\_

1. Please list any continuing complaints/symptoms since last Bio-Evaluation
2. Please list any new complaints or symptoms
3. Any new medications? If so, please list
4. Any negative reactions to previous remedies or nutritional supplementation?
5. Any positive reactions to previous remedies or nutritional supplementation?
6. What are your primary concerns for your Bio-Evaluation today?
7. Do you know anyone else who could benefit from a Bio-Evaluation?

**Remember:** Include this sheet and a \$150 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 bill 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 on file to pay for services and products: Yes \_\_\_ No \_\_\_

Authorized Signature: \_\_\_\_\_

**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**