

A Self-Assessment Health Questionnaire

First Name:			Last Name:		
Gender:	Male	Female	Age:	Height:	Weight:
Email Address:			Date:		
Home Address:			City:	State:	
Zip Code:	Country:		Province:		
Home Phone # ()			Cell Phone # ()		
Your Counselor may recommend Glandulars to 'power punch' certain areas. Please select your preference for Glandular recommendations:					
Preferred			Not Preferred		
Please Choose One:					
I currently use Dr. Morse's Formulas			I have never used Dr. Morse's Formulas before		
Vitals: If you are unsure of any of these readings, you may leave them blank.					
Blood Pressure: Right:		Left:	Eye Color:	Brown	Blue
Resting Pulse:		Basal Temp.	Urine pH:		Saliva pH:
How Many Bowel Movements do You Have Daily?			0 <input type="radio"/>	1-2 <input type="radio"/>	3-4 <input type="radio"/> 4 or more <input type="radio"/>
Are you taking any medications? Please list individually below:					
1.			5.		
2.			6.		
3.			7.		
4.			8.		
Are you taking any Herbal Products or Supplements? Please list individually below:					
1.			5.		
2.			6.		
3.			7.		
4.			8.		
What does your current daily diet consist of? Please be as honest as possible.					
Breakfast:					
Lunch:					
Dinner:					
Snack:					

What are your primary health concerns?

What do you hope to gain from this program?

Genetic / Family History
Please list all known health concerns for each family member. Leave blank if you aren't sure.

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sister/Brother:

Sister/Brother:

Sister/Brother:

Sister/Brother:

Previous Surgical Procedures
Please list all surgical procedures, minor or major, along with the year

	Year:
	Year:
	Year:
	Year:
	Year:

Do you, or have you ever had difficulty with any of the following?

Please circle all applicable, and indicate: Current, Past, or N/A

Thyroid/ Glandular System	Cold Hands or Feet	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Frequently Cold / Difficulty Warming	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Cold, but Burning Inside?	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Easy to Gain Weight and Hard to Lose It	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Irregular Heart Beat / Arrhythmia's (Also Adrenals/Cardiovascular)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Headaches / Migraines	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Easily Irritable	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Overweight	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Low Energy / Always Tired	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Goiter Hashimoto's Grave's Reidel's Disease	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Family Member with: Goiter Hashimoto's Grave's Reidel's Disease	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	How Much do You Sweat?	Low <input type="radio"/>	Medium <input type="radio"/>	Excessive <input type="radio"/>
	Parathyroid	Are Your Fingernails: (Check all Applicable)	Ridged <input type="radio"/>	Brittle <input type="radio"/>
Varicose Veins Spider Veins		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Hemorrhoids Prolapses		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Muscle Cramps / Legs Tire Easily		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Is Your Bladder:		Strong <input type="radio"/>	A Few Leaks <input type="radio"/>	Weak <input type="radio"/>
Hernia		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Aneurysm		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Low Bone Density Low Calcium		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Osteoporosis Scoliosis Kyphosis Lordosis		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Mental Health Challenges (Depression, PTSD, OCD, etc.) Please List:				
		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Spinal Deterioration Herniated Discs Bone Spurs		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Bruise Easy		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>

Pancreas	Slow Digestion	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Food Passes Quickly Through You (Diarrhea)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Acid Reflux Heartburn Indigestion	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Undigested Food in Stool	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Thin / Difficulty Gaining Weight	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Moles (Also Adrenals)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
Adrenals (Glandular System)	Overweight	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	MS ALS Parkinson's Palsey	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Anxiety	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Excessive Shyness / Inferiority Complex	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Tremors / Nervous Legs	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	High Blood Pressure (Also Cardiovascular)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Low Blood Pressure	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Hypoglycemia (Low Blood Sugar)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Diabetes: TYPE I TYPE 2	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Tinnitus (Ringing in Ears)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Difficulty Taking Deep Breath / S.O.B (Shortness of Breath)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Cardiac Arrythmia : (Also Cardiovascular) Please List Which Type:						
		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Sleep Challenges: Difficulty Getting to Sleep (Also Pineal)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Sleep Challenges: Difficulty Staying Asleep (Also Pituitary)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	CFS (Chronic Fatigue Syndrome)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Addison's Disease Congenital Adrenal Hyperplasia	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	High Cholesterol	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Do You Have <i>any</i> "Itis" Condition (Arthritis, Osteoarthritis, Bursitis, etc) Please List:						
		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Low Steroids / Low Cortisol	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	ADD ADHD Autism	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>

Females Only	Are You Currently Pregnant?		Yes	<input type="radio"/>	No	<input type="radio"/>				
	Are You Currently Breastfeeding?		Yes	<input type="radio"/>	No	<input type="radio"/>				
	Irregular Menses (Also Pituitary)		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Excessive Bleeding During Menstruation		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Ovarian Cysts	Fibroids	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Endometriosis	A- Typical Cells	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Fibrocystic Breasts		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Sore or Painful Breasts, Especially During Menstruation		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Low	Excessive	Sex Drive	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>	
	Have You Had a Complete Hysterectomy									
	Partial Hysterectomy		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	If Yes, Were Any Other Organs / Lymph Nodes Removed? Please List Which:									
	Males Only	Difficulty Conceiving		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>	
Birth Control Pills? For How Long:										
		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
Do You Have Prostatitis? How Often do You Urinate?		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
Have You Been Diagnosed With Prostate 'Cancer'?		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
What are Your PSA's?		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
Testicular Hypertrophy (Enlarged Testicles)		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
Gastro-Intestinal Tract	Low	Excessive	Sex Drive	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>	
	Erection Problems		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Premature Ejaculation		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Bowel Movements per Day:		0 - 1	<input type="radio"/>	2	<input type="radio"/>	3	<input type="radio"/>	4+	<input type="radio"/>
	Crohn's	Colitis	Gastritis							
	Enteritis	Diverticulitis	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Gastroparesis (Paralysis of the Stomach)		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Hiatus Hernia		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Coated Tongue, Especially Upon Waking: (white, yellow, green, brown)		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Diarrhea	Constipation	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
	Stomach	Intestinal	Ulcers	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>	
	Gastro-Intestinal 'Cancer': Please Provide Location of 'Cancer':		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>		
Gas Problems (Also Pancreas)		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			
Other GI Issues Not Listed:		Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>			

Liver/ Gallbladder / Blood	Difficulty Digesting Fats	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Fats or Dairy Cause Stomach Bloat / Pain	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Light Colored or White Stools	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Pain Mid-Back (Especially After Eating)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	'Liver' or Brown Spots (Not Freckles)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Skin Pigmentation Irregularities or Changes (Also Pituitary)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Jaundice of Eyes / Skin	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Anemia	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Hepatitis A B or C	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Alcohol Consumption:	Don't Drink <input type="radio"/>	Daily <input type="radio"/>	Weekly <input type="radio"/>
Cardiovascular	Angina / Chest Pain	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Myocardial Infarction (Heart Attack)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Pacemaker Stents Other Open Heart Surgery	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Do You Feel Pressure on Your Chest?	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Do You Feel 'Prickly' Pains? Please List Where:			
		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Skin	Blemishes Rashes Acne	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Dermatitis Eczema Psoriasis	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Dry, Itchy Skin	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Excessively Oily Skin	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Dandruff	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Any Other Skin Problems: Please List:			
		Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
	Do You Have Any Tattoos?	Yes <input type="radio"/>		No <input type="radio"/>

Lymphatic System

Hair Loss Balding Fully Bald (not by choice)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Have You Ever Had Any Lymph Nodes Removed? Yes <input type="radio"/>			No <input type="radio"/>
From Which Area of Your Body Were They Removed?			N/A <input type="radio"/>
How Many Were Removed?			N/A <input type="radio"/>
Swollen Lymph Nodes Lymphedema	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Do You Have Edema (Fluid Retention)? Please Provide Location:	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Fibromyalgia Scleroderma	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Cold & Flu-like Symptoms	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Sore Throat / Sinus Problems	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Poor Memory / Brain Fog	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Blurred Vision	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Mucus in Eyes Upon Waking	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Have You Been Diagnosed With 'Cancer' ? Please Provide Location:	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Other Type of Non-Malignant Mass / Tumor:	Fatty <input type="radio"/>	Benign <input type="radio"/>	N/A <input type="radio"/>
Location of Non-Malignant Mass / Tumor:			N/A <input type="radio"/>
AIDS / HIV +	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Low Platelet Count (Also Cardiovascular)	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Appendicitis / Appendectomy	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Date of Appendicitis / Appendectomy:			N/A <input type="radio"/>
Date of Tonsillectomy (Tonsils Removed):			N/A <input type="radio"/>
Boils Pimples Cysts Abscesses	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Gout	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Toxemia Cellulitis	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Sleep Apnea	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>
Do You Snore?	Current <input type="radio"/>	Past <input type="radio"/>	N/A <input type="radio"/>

Kidneys & Bladder	UTI Bladder Infection	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Cystitis	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Burning While Urinating	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Weak Bladder / Urinary Incontinence	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Restricted Urine Flow	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Kidney Stones	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Nephritis	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Cramping or Pain Mid-to Lower Back on Either Side	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Lower Back Weakness	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Sciatica	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
Bags Under Eyes	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>	
Respiratory System	Bronchitis Asthma COPD	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Emphysema Pneumonia	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Pain / Difficulty Breathing	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Pain / Difficulty Taking Deep Breaths (Also Adrenals)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Collapsed Lung: Right Left	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Frequent Cough	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Color of Mucus Expecterated: Clear Yellow	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Green Brown Black	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Do You Use a : Nebulizer Inhaler	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	What is Your Oxygen Saturation (or SP02)?	Don't Know <input type="radio"/>					
	Have You Been Diagnosed With Lung 'Cancer'?	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
Are You a Smoker?	Current	<input type="radio"/>	Past	<input type="radio"/>	Never Smoked	<input type="radio"/>	
How Much do You Smoke?	Packs/Day:		or	Cigarettes/ Day:			
Environmental and Other Toxic Exposure	Exposure to: Nuclear Wastes & By-Products	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Heavy Metals Toxic Chemicals	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Exposure to Toxic Substances Such as Asbestos or Coal Mines (Also Respiratory System)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Have You Gone Through Chemotherapy or Radiation?	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	How Many Treatments of Chemo or Radiation?						
	Have You Received the "Standard" Vaccinations?	Yes	<input type="radio"/>	No	<input type="radio"/>		
	Have You Received Vaccinations for Travelling to Foreign Countries?	Yes	<input type="radio"/>	No	<input type="radio"/>		
	Have You Received a Flu Shot?	Yes	<input type="radio"/>	No	<input type="radio"/>		
	Have You Ever Used 'Recreational' Drugs? (this information is confidential and used to help you attain optimal health only!)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Please List Any 'Recreational' Drugs You Have Used:						