CellPh & Wellness Assessment Questionnaire

HowToVeganATL@Gmail.COM

First Name: Last Name:

Gender: (Circle One) Male / Female Age: Height: (ft) (in) Weight: (lbs)

Email Address: Skype Name:

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: (Circle One) **Preferred** **Not Preferred**

(Circle One) I currently use Dr. Morse's Formulas /
I have used Dr. Morse's Formulas in the past / 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: (Circle One) Brown Blue

Resting Pulse: (bpm) Basal Temp. (F) Urine pH: Saliva pH:

How Many Bowel Movements do You Have Daily? **0 - 1** ○ **2** ○ **3** ○ **4 or More** ○

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

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

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

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

Lymphatic System

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

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