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** ☐

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** ☐ **1-2** ☐ **3-4** ☑ **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 ☐	Current ☐	Past ☐	N/A ☐		
	Family Member with: Goiter ☐ Hashimoto's ☐ Grave's ☐ Reidel's Disease ☐	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 ☐	Current ☐	Past ☐	N/A ☐		
	Hemorrhoids ☐ Prolapses ☐	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 ☐	Current ☐	Past ☐	N/A ☐		
	Osteoporosis ☐ Scoliosis ☐ Kyphosis ☐ Lordosis ☐	Current ☐	Past ☐	N/A ☐		
	Mental Health Challenges (Depression, PTSD, OCD, etc.) Please List:	Current ☐	Past ☐	N/A ☐		
	Spinal Deterioration ☐ Herniated Discs ☐ Bone Spurs ☐	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 ☐	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 ☐	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: **TYPE I** ☐ **TYPE 2** ☐	Current ☐	Past ☐	N/A ☐
	Tinnitis (Ringing in Ears)	Current ☐	Past ☐	N/A ☐
	Difficulty Taking Deep Breath / S.O.B (Shortness of Breath)	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 ☐	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 ☐	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 ☐	Current	☐	Past	☐	N/A	☐
	Endometriosis ☐ A-Typical Cells ☐	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	Current	☐	Past	☐	N/A	☐
	Have You Had a Complete Hysterectomy Partial Hysterectomy	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	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 ☐	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)	Current	☐	Past	☐	N/A	☐
	Diarrhea ☐ Constipation ☐	Current	☐	Past	☐	N/A	☐
	Stomach ☐ Intestinal ☐ Ulcers	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	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	Current ☐	Past ☐	N/A ☐
Anemia	Current ☐	Past ☐	N/A ☐
Hepatitis A ☐ B ☐ or C ☐	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 ☐	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 ☐	Current ☐	Past ☐	N/A ☐
Dermatitis ☐ Eczema ☐ Psoriasis ☐	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) ☐	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 ☐	Current	☐	Past	☐	N/A	☐
Do You Have Edema (Fluid Retention)? Please Provide Location:	Current	☐	Past	☐	N/A	☐
Fibromyalgia ☐ Scleroderma ☐	Current	☐	Past	☐	N/A	☐
Cold & Flu-like Symptoms	Current	☐	Past	☐	N/A	☐
Sore Throat / Sinus Problems	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	Current	☐	Past	☐	N/A	☐
Date of Appendicitis / Appendectomy:					N/A	☐
Date of Tonsillectomy (Tonsils Removed):					N/A	☐
Boils ☐ Pimples ☐ Cysts ☐ Abscesses ☐	Current	☐	Past	☐	N/A	☐
Gout	Current	☐	Past	☐	N/A	☐
Toxemia ☐ Cellulitis ☐	Current	☐	Past	☐	N/A	☐
Sleep Apnea	Current	☐	Past	☐	N/A	☐
Do You Snore?	Current	☐	Past	☐	N/A	☐

Kidneys & Bladder	UTI ☐ Bladder Infection ☐ Cystitis ☐	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	Current ☐	Past ☐	N/A ☐
	Sciatica	Current ☐	Past ☐	N/A ☐
	Bags Under Eyes	Current ☐	Past ☐	N/A ☐
Respiratory System	Bronchitis ☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐	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 ☐ Left ☐	Current ☐	Past ☐	N/A ☐
	Frequent Cough	Current ☐	Past ☐	N/A ☐
	Color of Mucus Expectorated: Clear ☐ Yellow ☐ Green ☐ Brown ☐ Black ☐	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 ☐ Heavy Metals ☐ Toxic Chemicals ☐	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:			