



Health Questionnaire & Assessment

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Please print clearly! Use a dark colored ink to ensure readability.

<u>Personal Information</u>		Date Completed:	
Name: _____	Gender: M F	Age: _____	
Height: _____ (ft.)	Weight: _____ (lbs.) OR _____ (kgs.)	Date of Birth: _____	
Address: _____		City: _____	
State: _____	Zip Code: _____	Email: _____	
Country: _____	Province: _____	Int'l Dialing Code: _____	
Phone: _____	Cell Phone: _____	Alt. Phone: _____	
Skype: _____	I have worked with Dr. Morse's formulas before:	YES	NO
Family Physician:	Yes. The information is listed below. No. I do not have a family physician.		
Physician Information:			

<u>Vitals Information</u> <i>If you are not sure of your vital sign readings you may leave them blank.</i>			
Eye Color: _____	Blood Pressure – Left: _____	Blood Pressure – Right: _____	
Pulse: _____	Respirations: _____	Basal Temp.(F): _____	pH (urine or saliva): _____
How many bowel movements do you have per day? How often do you move your bowels per week?			
What does your current diet consist of? Be honest!			
The Counselor may recommend glandulars to “power punch” certain glands. Please let us know as to whether or not you would like glandulars considered. Select one: YES NO			

THYROID (GLANDULAR SYSTEM)

YES	NO	Do you get cold hands and/or feet?
YES	NO	Do you feel cold often or have a hard time getting warm?
YES	NO	Are you cold, but burning inside?
YES	NO	Is it easy to put on weight and hard to lose it?
YES	NO	Do you have an irregular heartbeat?
YES	NO	Do you get headaches or migraines?
YES	NO	Do you become irritable easily?
YES	NO	Do you have low energy levels?
YES	NO	Do you have, or have you ever had, a goiter?
YES	NO	Have you been diagnosed with Hashimoto or Reidel disease? Has a family member?
—————→		How much do you sweat? Low Medium Excessive

PARATHYROID (GLANDULAR SYSTEM)

YES	NO	Are your fingernails ridged , brittle or weak ?
YES	NO	Do you have varicose or spider veins?
YES	NO	Do you, or have you had, hemorrhoids or prolapsed organs ?
YES	NO	Do you experience cramping in your muscles?
—————→		Is your bladder strong or weak? Strong Weak
YES	NO	Have you ever had a hernia?
YES	NO	Have you ever had an aneurysm?
YES	NO	Do you have osteoporosis and/or score low on your bone density tests?
YES	NO	Do you have scoliosis?
YES	NO	Do you suffer from symptoms of depression?
YES	NO	Do you suffer from any other mental illness? Which? _____

PARATHYROID (GLANDULAR SYSTEM) *Continued from page 2*

YES	NO	Do your tests come back showing low Calcium levels?
YES	NO	Do you have spine deterioration, herniated discs, or bone spurs?
YES	NO	Do your legs get tired or cramp after you walk?
YES	NO	Do you bruise easily?

PANCREAS

YES	NO	Do you get gas after you eat?
YES	NO	Do you feel your foods just sitting in your stomach?
YES	NO	Do you have Acid Reflux?
YES	NO	Do you see any undigested foods in your stools?
YES	NO	Are you thin and have a hard time putting on weight?
YES	NO	Do your foods pass right through you (diarrhea)?
YES	NO	Do you have moles on your body? (Adrenal & Pancreatic weakness)

ADRENAL GLANDS (GLANDULAR SYSTEM)

YES	NO	Are you overweight?
YES	NO	Do you have M.S. , Parkinson's or Palsy ?
YES	NO	Do you have anxiety attacks or feel overly anxious?
YES	NO	Do you feel excessive shyness or inferior to others?
YES	NO	Do you have tremors, nervous legs, etc.?
YES	NO	Do you have High or Low Blood Pressure? _____ → Systolic _____ Diastolic _____
YES	NO	Do you have hypoglycemia (low blood sugar)?
YES	NO	Do you have Diabetes (high blood sugar)? _____ → If yes: TYPE I or TYPE II
YES	NO	Do you have tinnitus (ringing in the ears)?
YES	NO	Do you have S.O.B. (shortness of breath) or is it hard to take a deep breath?

ADRENAL GLANDS (GLANDULAR SYSTEM) *Continued from Page 3*

YES	NO	Do you have heart arrhythmias?
YES	NO	Do you have a hard time sleeping or insomnia? (pineal)
YES	NO	Do you have Chronic Fatigue Syndrome?
YES	NO	Have you ever been diagnosed with Addison's Disease or Congenital Adrenal Hyperplasia ?
YES	NO	Do you have elevated blood cholesterol levels?
YES	NO	Do you have arthritis, bursitis, or any inflammatory issues?
YES	NO	Do you have any "itis's (inflammatory conditions)? → Which? _____ (arthritis, bursitis, rheumatoid arthritis, colitis, enteritis, phlebitis, neuritis, etc.)
YES	NO	Do you have low steroid or cortisol levels?
YES	NO	Have you been diagnosed with Autism?
YES	NO	Have you been diagnosed with ADD (attention deficit disorder) or ADHD (attention deficit hyperactivity disorder)?

FEMALES ONLY

YES	NO	Are your menstruation cycles irregular? (pituitary)
YES	NO	Do you have excessive bleeding during menstruation?
YES	NO	Do you have or have you had ovarian cysts? When? _____
YES	NO	Do you have or have you had fibroids? When? _____
YES	NO	Do you have or have you had endometriosis or A-typical cells? → Which ones? _____
YES	NO	Do you have or have you had fibrocystic breasts? When? _____
YES	NO	Do you get sore breasts, especially during menstruation?
YES	NO	Do you have a low or excessive sex drive?
YES	NO	Have you had a hysterectomy? → Date: _____ Was it: Partial Complete

FEMALES ONLY *Continued from page 4*

YES	NO	Did they take any other organs out at the same time? (i.e.: gallbladder) If yes, what other organs?
→		_____
YES	NO	Have you had a D & C? If yes, date: _____
YES	NO	Have you had a miscarriage? When? _____
YES	NO	Have you had difficulty conceiving children in the past or recently ?
YES	NO	Have you been on Birth Control Pills? For how long? : _____
YES	NO	Are you currently pregnant?

MALES ONLY

YES	NO	Do you have prostatitis (frequent urination esp. at night)?
→		If yes, how often do you urinate?: _____
YES	NO	Do you have prostate cancer?
→		What are your PSA counts?: _____ date: _____
YES	NO	Do you have testicular hypertrophy (enlargement)?
YES	NO	Do you have a low or excessive sex drive?
YES	NO	Do you have erection problems?
YES	NO	Do you have premature ejaculation?
→		Other: _____

GASTRO-INTESTINAL TRACT

YES	NO	Do you have gastritis or enteritis?
YES	NO	Is your tongue coated (white, yellow, green or brown), especially in the morning?
YES	NO	Do you have gastroparesis?
YES	NO	Do you have a Hiatus Hernia?
YES	NO	Do you have Colitis?
YES	NO	Do you have Diverticulitis?
YES	NO	Do you get or have Diarrhea?

GASTRO-INTESTINAL TRACT *continued from page 5*

YES	NO	Do you get or have Constipation?
YES	NO	Have you ever had stomach or intestinal ulcers?
YES	NO	Do you or have you had any type of gastro-intestinal cancers? (stomach, colon, rectal, etc.)
<p>—————→</p>		Explain: _____
YES	NO	Do you have Crohn's Disease?
YES	NO	Do you have "gas" problems?
<p>—————→</p>		Other GI problems: _____

LIVER / GALLBLADDER / BLOOD

YES	NO	Do you have a problem digesting fats?
YES	NO	Do fats or dairy foods cause bloating and/or pain in the stomach area?
YES	NO	Are your stools white, or very light brown in color?
YES	NO	Do you get pain in the middle of your back (especially after eating)?
YES	NO	Do you get pain behind the right, lower rib area?
YES	NO	Do you have "liver" or brown spots on your skin? (not freckles)
YES	NO	Are you Jaundiced (yellowing of the skin) or eyes?
YES	NO	Do you have any skin pigmentation changes?
YES	NO	Are you or have you ever been anemic?
YES	NO	Do you have, or have you ever had, hepatitis? If so: A , B , C .
YES	NO	Do you consume alcohol regularly? How often? _____

HEART AND CIRCULATION

YES NO Do you get chest pains or angina?

YES NO Have you ever had a heart attack (Myocardial Infarction)?

YES NO Have you ever had open-heart surgery?

YES NO Do you have heart arrhythmia's?

—————→ What kind? _____

YES NO Do you ever feel pressure on your chest?

YES NO Do you get "prickly" pains anywhere, especially in the heart area?

—————→ Where? _____

YES NO Do you have, or have you ever had High Blood Pressure? (kidneys)

YES NO Do you have a **Pacemaker** or **Stents** ?

SKIN

YES NO Do you get or have skin rashes?

YES NO Do you get skin blemishes?

YES NO Do you have Eczema or Dermatitis?

YES NO Do you have Psoriasis?

YES NO Do you itch anywhere? Where?

YES NO Is your skin dry?

YES NO Is your skin excessively oily?

YES NO Do you get or have dandruff?

YES NO Do you have any other skin problems?

—————→ If so, what type? _____

YES NO Do you have any tattoos? If so, where and how much of your body is covered?

—————→ _____
What is the approximate date of the most recent tattoo? _____

LYMPHATIC SYSTEM

YES	NO	Do you have hair loss or are you bald or going bald?
YES	NO	Have you ever had Lymph Nodes removed? Where and how many? → _____
YES	NO	Do you have any gray hair?
YES	NO	Do you have a hard time remembering things?
YES	NO	Do you ever get colds or flu-like symptoms?
YES	NO	Do you have fibromyalgia or scleroderma?
YES	NO	Do you have sinus problems?
YES	NO	Do you have or get sore throats?
YES	NO	Do you have swollen lymph nodes?
YES	NO	Do you have or have you had tumors? → If so, where?: _____ → Type: Fatty Benign Malignant
YES	NO	Do you have a low platelet count (blood)?
YES	NO	Have you had appendicitis or an appendectomy? When? _____
YES	NO	Do you get boils, pimples, cysts, etc.?
YES	NO	Do you get regular exercise? How many times per week? _____ → What type of exercise? _____
YES	NO	Have you ever had abscesses?
YES	NO	Have you ever had toxemia?
YES	NO	Do you have, or have you had, cellulitis? (<i>not cellulite – this is different!</i>)
YES	NO	Have you ever had gout?
YES	NO	Do you get blurred vision?
YES	NO	Do you have mucus in your eyes when you wake up in the morning?

LYMPHATIC SYSTEM *continued from page 8*

YES NO Do you snore?

YES NO Do you have sleep apnea?

YES NO Have you had your tonsils out? What age? _____

KIDNEYS AND BLADDER

YES NO Have you ever had a urinary tract infection (UTI's)?

YES NO Have you ever had "burning" upon urination?

YES NO Do you have problems holding your bladder? (parathyroid)

YES NO Have you ever had kidney stones?

YES NO Do you have bags under your eyes (esp. in the morning)?

YES NO Is your urine flow restricted?

YES NO Do you get cramping or pain on either side of your mid-to-lower back?

YES NO Do you or did you ever have nephritis?

YES NO Do you have lower back weakness?

YES NO Do you have or have you had sciatica?

YES NO Do you or did you ever have cystitis?

LUNGS

YES NO Do you get or have (or have had) bronchitis?

YES NO Do you get or have (or have had) emphysema?

YES NO Do you get or have (or have had) asthma?

YES NO Do you get or have (or have had) C.O.P.D?

YES NO Are you on inhalers or nebulizers? How often? _____

—————> What medication? _____

—————> Your oxygen saturation level is _____.

YES NO Do you have pain when you breathe?

LUNGS *continued from page 9*

YES	NO	Do you have pain when you take a deep breath? (adrenals)
YES	NO	Is it difficult to take a deep breath?
YES	NO	Did you ever or do you have lung cancer? When? _____
YES	NO	Do you or did you have a collapsed lung? When? _____
YES	NO	Are you a smoker? <input type="checkbox"/> → How often? _____ Packs per day OR _____ cigarettes per day
YES	NO	Have you ever had pneumonia? When and how often? _____
YES	NO	Have you ever worked around toxic chemicals, in coal mines or around asbestos?
YES	NO	Do you cough a lot?
YES	NO	Do you remove any mucus when you cough? <input type="checkbox"/> → What color is the mucus? (clear, yellow, green, brown or black?) _____

ENVIRONMENTAL AND OTHER TOXINS

YES	NO	Have you been vaccinated?
YES	NO	Have you had shots for traveling to foreign countries?
YES	NO	Have you had Flu shots?
YES	NO	Do you have mercury Amalgams?
YES	NO	Have you been exposed to nuclear wastes or by-products, heavy metals or chemicals?
YES	NO	Have you had radiation or chemotherapy ? <input type="checkbox"/> → If so, how many treatments? _____
YES	NO	Have you ever used any form of recreational drugs? (this information is confidential and used to help you obtain optimal health only!) If so, which drugs? _____
<input type="checkbox"/> →		Do you still use them? YES NO

PAST SURGERIES *(List any surgeries you have had, minor and major along with the year)*

1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

GENETIC/FAMILY HISTORY *(List the health issues - if known - of each family member)*

Mother:
Father:
Maternal Grandmother:
Maternal Grandfather:
Paternal Grandmother:
Paternal Grandfather:
Sibling:
Sibling:
Sibling:
Sibling:

WHAT ARE YOUR MAJOR HEALTH COMPLAINTS OR CONCERNS?

Please list any conditions or symptoms that were not covered in this questionnaire.

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