



A Self-Assessment Health Questionnaire

First Name:		Last Name:			
Gender:	Male	Female	Age:	Height:	Weight:
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:					
Preferred			Not Preferred		
Please Choose One:					
I currently use Dr. Morse's Formulas			I have never used Dr. Morse's Formulas before		
I 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: 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 / Arrythmia's <i>(Also Adrenals/Cardiovascular)</i>	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: <i>(Check all Applicable)</i>	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:						
	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"/>
Males Only	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"/>
	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"/>
Gastro-Intestinal Tract	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"/>	Monthly or Less
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 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 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 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:						