



First Name:		Last Name:	
Gender:	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 <i>'power punch'</i> 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?			
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) Varicose Veins / Spider Veins	Ridged <input type="radio"/>	Brittle <input type="radio"/>
		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 / Palsy	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 (Short of Breath)	Current	<input type="radio"/>	Past	<input type="radio"/>	N/A	<input type="radio"/>
	Cardiac Arrhythmia : (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 any "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 / Atypical 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"/>		
	Males Only	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"/>		
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"/>
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:			
	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(s):	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 / 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 / Lack of Strength	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 or 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 of Nuclear Wastes / Heavy Metals / Toxic Chemicals	Current <input type="radio"/>	Past <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:				