



Complete all Forms, sign the acceptance and Fax to Toll Free **1-866-850-7619**

Part 1 GENERAL INFORMATION

Name: _____ **Date of Birth:** _____

Year of Birth - Mom _____ **Year of Birth- Dad** _____

Current Address: _____ **City:** _____

Prov./State: _____ **Zip/Postal Code:** _____ **Phone:** _____

Home Phone #: _____ **Work #** _____

Email Address: _____

ViralScore™ Referred by: _____

Do you currently take vitamins or other supplements: _____ **No** **Yes**

If yes, please list On Separate sheet _____

PART 2: Section 1: MEDICATIONS

Please check any of your following conditions/medications or medical procedures you are currently taking or have done up to today's date.

- Antacids Pain Medications Anti-inflammatory Medications Steroids
- Antibiotics Antidepressants High Blood Pressure Laxatives
- CT Scan Heart Medications Oral Contraceptives Thyroid
- MRI Scan Water Retention Chemotherapy Ulcer
- Other – please list _____

Family History (Please check any that applies)

- Diabetes Heart Disease/hypertension Hepatitis/Liver Disease Stroke
- Cancer Lyme Alcohol related Emotional/Mental disorders
- Other – please list _____

Childhood History (Please check any that applies)

- Measles Dry cough Sinus problems Slow learner
- Mumps Skin breakouts Chickenpox Mono
- Strep throat Ear infections Received all vaccinations Other – please list _____

Number of glasses of water daily _____ **Food intake last 24 hours – list on separate sheet**

Bottled, Well and or Tap Municipal (circle) _____ **Sugar Types/Day Artificial/Natural** _____

Number of times/Smoke/Day _____ **Number Alcohol Drinks/Day** _____

Number of amalgam/fillings _____ **Number of caffeine/products** _____

Number of Known allergies _____ **Number of major injuries/Past** _____

Number of major infections/past _____ **How many pounds overweight** _____

Personal Stress - work (1-10) _____ **Personal Stress – home (1-10)** _____

Cosmetic types used – Please list _____

The following information is provided to this facility for nutritional information. The information being sought is of a nutritional nature and not a medical diagnosis, treatment, disease prevention or health assessment. I hereby certify that I am not an employee, agent, or otherwise affiliated with the Federal Drug Administration, Health Canada, or a related agency. I further understand: According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "Drug" is defined to mean; Articles intended for the use in the DIAGNOSIS, CURE, MITIGATION or PREVENTION of disease. In other words, to "say" that vitamin, mineral, trace or amino acids will have any effect on disease or symptoms thereof, that a particular nutrient then becomes a DRUG under the law as written. Therefore, any suggested nutrition is not intended as primary therapy for any disease or symptom, but is provided safely to upgrade the quality of foods delivered through the diet. By providing information you are aware that you are consenting for information to be used under the name ViralScore™-Nutritional Self-Evaluation. Information provided will be used for statistical gathering of data purposes only. No confidential information obtained will be used for any other purpose other than the ViralScore™ program.

Signature of Client/Member _____ Date _____



Nutritional Self/Evaluation

Previously Diagnosed Conditions: Please check all items that have affected your health!

- | | |
|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hashimoto's disease |
| <input type="checkbox"/> Allergies – airborne | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Allergies –food | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Allergies –food | <input type="checkbox"/> Hyperactivity – ADD |
| <input type="checkbox"/> Arthritis – osteo | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Arthritis – rheumatoid | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Allergies –food | <input type="checkbox"/> Lyme |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Auto immune disease | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> MS |
| <input type="checkbox"/> Cholesterol – need to lower | <input type="checkbox"/> Pain Identification – chronic |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pain Identification – trauma –
accident |
| <input type="checkbox"/> Crohn's syndrome | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Post War Syndrome |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> P.M.S |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Gastritis | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Grave's disease | <input type="checkbox"/> Urinary tract inflammation |
| <input type="checkbox"/> Hair loss – Alopecia | <input type="checkbox"/> Vasculitis |
| <input type="checkbox"/> Hair loss – Crown | <input type="checkbox"/> Vitiligo |
| <input type="checkbox"/> Hair loss – Overall thinning | |

Please list foods and fluids consumed in the last 24 hours.



Acidosis –Chemical/Heavy metal toxicity Self Evaluation / Assessment

Neurological (Brain Function)

- Chronic or frequent headaches
- Numbness and tingling anywhere
- Dizziness
- Ringing or noises in the ear
- Tremors in hands, feet, lips, eyelids

Psychological (Liver, Kidneys, Bladder)

- Irritability
- Nervousness
- Shyness or timidity
- Loss of memory
- Inability to concentrate
- Mood changes
- Attention Deficit Syndrome
- Decline of intellect
- Loss of self-confidence
- Anger and loss of self control
- Depression
- Crying spells
- Anxiety
- Drowsiness
- Insomnia

Oral Cavity

- Bleeding gums
- Bone loss and loosening of teeth
- Foul breath
- Excessive salivation
- Metallic taste
- Chronic inflammation of gums

Digestive/ Immune & Gut dysfunction

- Abdominal cramps
- Constipation or diarrhea
- Irritable bowel syndrome
- Colitis
- Nausea
- Loss of appetite
- Voracious appetite and obesity
- Excessive thirst

Cardiovascular

- Irregular heartbeat
- Alterations in blood pressure

Inflammatory and immunological (Lungs, Large Intestine)

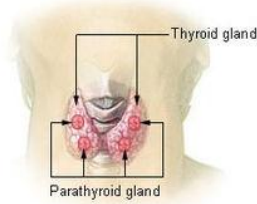
- Chronic Fatigue Syndrome
- Fibromyalgia
- Rheumatoid arthritis
- Allergies
- Sinusitis
- Asthma
- Muscle weakness and joint pain

Other problems

- Excessive perspiration without fever
- Low body temperature/clamminess
- Skin rashes, especially around face/neck
- Dim or double vision
- Hypoxia (lack of oxygen)
- Optic nerve degeneration

Thyroid Symptom Survey

Thyroid and Parathyroid Glands



Client Name _____ DATE _____

SYMPTOM RATING

(0) I DO NOT HAVE THIS (1) MILD (2) MODERATE (3) SEVERE

HYPO- SYMPTOMS

- Lumps in Breast _____
- More tired and sluggish than normal. _____
- Drier hair and skin than normal _____
- Sleep more than usual _____
- Weaker Muscles _____
- Colder than others _____
- Muscles cramp more than usual _____
- Poorer memory _____
- More depressed _____
- Slower thinking _____
- Eyes are more puffy _____
- Math is more difficult _____
- Hoarser or deeper voice _____
- Constipated more often _____
- Coarser Hair _____
- Puffy hands and feet _____
- Unsteady when walking _____
- Gain weight easily _____
- Outer third of eyebrow thin _____

- Menstruating Females Only _____
- Lumpy, Fibrous Breasts _____
- Menses more irregular _____
- Heavier Menses _____

TOTAL _____

HYPER- SYMPTOMS

- Tachycardia (heart racing) _____
- Palpitations (skipping of heart) _____
- Insomnia (don't sleep well) _____
- Tremors (shaking) _____
- Increased sweating _____
- Brittle nails _____
- Loss of appetite _____

TOTAL _____

GRAND TOTAL _____

- **0 – 9 Unlikely you are hypothyroid**
- **10 – 19 Mild hypothyroidism**
- **20 – 29 Moderate hypothyroidism**
- **30+ Sever hypothyroidism**