COOPER
HEALTH SOLUTIONS

HEALTH PARTICIPATION
CLIENT INTAKE FORM
(Please Print)

Today's date:

CLIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Are you a previous client? ❑ Yes ❑ No	Preferred appointment day/time?	(Former name):	Birth date: / /	Age:	Gender: ❑ M ❑ F	
E-mail address:		Preferred method of contact: ❑ Home phone ❑ Cell phone ❑ Text message ❑ E-mail				
Street address:		Cell phone: ( )	Home phone: ( )			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	❑ Sedentary ❑ Mildly active	❑ Moderately active ❑ Highly active	Employer:			

Chose us because/Referred to us by (please check one box): ❑ Dr. _____ ❑ Other practitioner _____

❑ Family ❑ Friend ❑ Website ❑ Social Media ❑ Other (please specify) _____

Other family members seen here:

REASON FOR VISIT/GOALS

What would you like to achieve? (Health, Wellness, Fitness, Weight/Body Composition)
(Please provide a specific and prioritized list)

How will reaching these goals impact your life? Why is it important to you?

Readiness for change and commitment to your goals:	Please rate yourself with 1 the least and 10 the highest									
Commitment to achieving your goals	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Confidence for success	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Priority in your life	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Support system	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Who is supporting you? (Please list family, friends or other)

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WELLNESS HISTORY

Basic Measurements

Height		Weight (lbs)		Body Fat %	

Activity

Do you exercise or do any fun sweaty activity? ❑ Yes ❑ No	Frequency? ❑ Daily	❑ 1-2x/wk	❑ 3-4x/wk	❑ 5-7x/wk	
If no, does anything prevent you?					

What type?	Method:	How many hours per week?
❑ Strength/Resistance	❑ Total Body ❑ Splits ❑ Cross Fit style ❑Other _____	
❑ Cardiovascular	❑ Run/Jog ❑ Bike ❑ Elliptical ❑ Walk ❑ Other _____	
❑ Yoga / Pilates	❑ Hot ❑ Restorative ❑ Reformer ❑ Mat ❑ Other _____	
❑ Other (please specify)		

Sleep & Stress

What time do you go to bed? am/pm	What time do you wake up? am/pm	How many hours?
How long does it take you to fall asleep? ❑ Fall right to sleep (under 15 minutes) ❑ _____ minutes		
Do you use anything to fall asleep? ❑ Read ❑ TV ❑ Screen time ❑ Meditation/Music/White Noise ❑ Meds/Supplements (below)		
How many times do you wake at night?	Please specify any meds or supplements to aid sleep:	
Do you fall right back to sleep? ❑ Yes ❑ No		

Morning energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Afternoon energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Evening energy (10 is highest)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10
Stress level (10 is worst)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	❑ 6	❑ 7	❑ 8	❑ 9	❑ 10

Stressors:
How do you manage your stress?

Nutrition

Do you follow any special diet? (Mediterranean, Kosher, Gluten free, vegetarian, intermittent fasting etc.) ❑ Yes ❑ No			
Please specify:			
Do you follow this diet for religious or moral beliefs? ❑ Yes ❑ No			
Are you willing to consider changing this diet? ❑ Yes ❑ No			
How often do you eat out per week?	Where?		
How much water do you consume daily (in ounces)?			
Type of water? (circle all that apply) Tap / Filtered / Reverse Osmosis / Alkaline / Bottled / Spring / Distilled			
How much coffee do you consume daily (in ounces)?	Caffeinated ❑ Yes ❑ No		
How much soda do you consume daily (in ounces)?	Caffeinated ❑ Yes ❑ No		
Alcohol consumption?	Number of drinks per week:	Type?	
Do you do the cooking? ❑ Yes ❑ No	Do you like to cook? ❑ Yes ❑ No		
Do you do the shopping? ❑ Yes ❑ No	Where do you shop for food?		
Do you have cravings? ❑ Yes ❑ No	Do you eat out of emotions? (stress, depression, boredom, etc.) ❑ Yes ❑ No		
What type of cravings? ❑ Sugar ❑ Salt ❑ Starch	Specify craving and time of day:		

Typical day of eating			
Meal	Time of Day	Location (home prepared or out)	Type of food or drink and quantity
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Supplementation							
Supplement / Brand / Serving	Time of Day	With meal?		Supplement / Brand / Serving	Time of Day	With meal?	
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No
		❑ Yes	❑ No			❑ Yes	❑ No

Health History					
Do you smoke? ❑ Yes ❑ No	Have you ever smoked? ❑ Yes ❑ No	How long ago? years months			
Do you experience gassiness or bloating after meals or at any other time? ❑ Yes ❑ No	When?				
What foods?					
Do you have daily bowels movements? ❑ Yes ❑ No	How many per day?	Consistency? Firm / Loose / Greasy / Pebbles			
Please list any injuries and when:					
Please list any surgeries and when:					

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Women's Health					
Menstrual cycle? ❑ Yes ❑ No	❑ Normal ❑ Irregular	❑ Normal flow	❑ Heavy flow	❑ Light flow	
Days between periods?	Date of last period?	❑ Perimenopausal	❑ Menopausal	❑ Postmenopausal	
Pregnant? ❑ Yes ❑ No	If yes, due date?	Did you have an operation that stopped your period? ❑ Yes ❑ No			
Breast feeding? ❑ Yes ❑ No	Breast Implants? ❑ Yes ❑ No	Date of last surgery?	How many surgeries?		

Symptoms, Medical Diagnoses (by a licensed medical practitioner) and/or Areas of Concern:

❑ Acne	❑ Cholesterol High / Low (circle)	❑ Herpes	❑ Parasites
❑ ADD/ADHD	❑ Circulation	❑ Hiatal Hernia	❑ Parkinson's Disease
❑ Adrenal Glands	❑ Cold - Common	❑ Hives	❑ Perspiration
❑ Allergies (list below)	❑ Cold - Temperature	❑ Hormones	❑ PMS
❑ Alzheimer's Disease	❑ Colic	❑ Hyperactive	❑ Pneumonia
❑ Anemia	❑ Colon	❑ Hypertension	❑ Polyps
❑ Anger	❑ Constipation	❑ Hyperthyroidism	❑ Pregnancy
❑ Anxiety	❑ Cough	❑ Hypoglycemia	❑ Prostate
❑ Appetite	❑ Cravings	❑ Hypothyroidism	❑ Psoriasis
❑ Arteriosclerosis	❑ Dandruff	❑ Impotence	❑ Rash
❑ Arthritis	❑ Depression	❑ Incontinence	❑ Reproductive
❑ Asthma	❑ Diabetes	❑ Indigestion	❑ Respiratory
❑ Autoimmune (list below)	❑ Diarrhea	❑ Insomnia	❑ Rheumatism
❑ Back Pain	❑ Digestion	❑ Joint Pain	❑ Ringworm
❑ Bad Breath	❑ Dizzy Spells	❑ Kidney Issues	❑ Seizures
❑ Bed Wetting	❑ Ear Infection	❑ Kidney Stones	❑ Shingles
❑ Bell's Palsy	❑ Ear Ringing	❑ Laryngitis	❑ Sinus
❑ Bites	❑ Edema	❑ Leprosy	❑ Skin Issues
❑ Bladder	❑ Emphysema	❑ Leukemia	❑ Snoring
❑ Blood Pressure - High	❑ Epilepsy	❑ Libido decreased	❑ Sore Throat
❑ Blood Pressure - Low	❑ Eyesight	❑ Liver Stress	❑ Stomach
❑ Boils	❑ Fatigue	❑ Lung Issues	❑ Stroke
❑ Bones	❑ Fever	❑ Lupus	❑ Sty
❑ Breathing	❑ Flu	❑ Lyme Disease	❑ Teething
❑ Bronchitis	❑ Gallstones	❑ Lymph Glands	❑ Tennis Elbow
❑ Bruises	❑ Gangrene	❑ Menopause	❑ Tonsillitis
❑ Burns	❑ Gas / Bloating	❑ Menstrual Cramps	❑ Tumors
❑ Cancer	❑ Gout	❑ Migraines	❑ Ulcers
❑ Candida	❑ Gums	❑ Mononucleosis	❑ Urinary Infections
❑ Canker Sores	❑ Hair Issues	❑ Mucous	❑ Varicose Veins
❑ Carpal Tunnel	❑ Headache	❑ Nails	❑ Vertigo
❑ Cataracts	❑ Heart Issues	❑ Nausea	❑ Weight - Overweight
❑ Chest Congestion	❑ Heartburn	❑ Nervousness	❑ Weight - Underweight
❑ Chest Pain	❑ Hemorrhoids	❑ Nose Bleeds	❑ Yeast Infections

OTHER:

Allergies:
Food Sensitivities:
Environmental/Chemical Sensitivities:

Dental History			
Current amalgam (“silver”) fillings? ❑ Yes ❑ No		Have you had amalgam fillings removed? ❑ Yes ❑ No	
Do you have any root canals? ❑ Yes ❑ No		Date you had amalgams removed?	
Do you have any dental implants? ❑ Yes ❑ No			
Have you had any teeth removed (including Wisdom teeth)? ❑ Yes ❑ No		How many?	

Medications (prescription and OTC)					
Medication	Dose	How long?	Medication	Dose	How long?
		years months			years months
		years months			years months
		years months			years months
		years months			years months
		years months			years months

Anything else you would like me to know?

CLINICAL ASSESSMENT QUESTIONNAIRE

SUPPORT ORGANS & SYSTEMS

Instructions

Rate each of the following symptoms to the best of your ability based on the last **30 days**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Blood Sugar				
Crave Sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Fatigue after meals	0	1	2	3
Must have sweets after meals	0	1	2	3
Forgetful; poor memory	0	1	2	3
Feel better or calmer after eating	0	1	2	3
Prone to infections or colds	0	1	2	3
History of diabetes in your family		N	Y	=4
Sugar (glucose) detected in urine test?		N	Y	=4
Hair loss under your socks?		N	Y	=10

Blood Sugar total: _____

Green 0-10	Yellow 11-24	Red 25-45

Stomach				
Belching, bloating, or burping	0	1	2	3
Gas quickly following a meal	0	1	2	3
Bad breath	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in the stool	0	1	2	3
Stomach pain, burning, or aching 1 to 4 hours after eating	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, or caffeine	0	1	2	3
Indigestion	0	1	2	3
Abdominal bloating	0	1	2	3
Constipation	0	1	2	3
Diminished appetite	0	1	2	3

Stomach total: _____

Green 0-11	Yellow 12-26	Red 27-36

SIBO (Small Intestinal Bacterial Overgrowth)				
Abdominal distension after consumption of fiber, starches, or sugar	0	1	2	3
Abdominal distension after taking certain probiotics or other dietary supplements	0	1	2	3
Abdominal distention, bloating or a noisy gut after eating healthy vegetables	0	1	2	3
Bloating or feeling full in upper abdominal area *(just below rib cage)*	0	1	2	3

SIBO total: _____

Green 0-1	Yellow 2-4	Red 5-12

Small Intestine				
Increased gut motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Mucus in stool	0	1	2	3
Poorly formed or loose stools	0	1	2	3
Four or more large stools daily	0	1	2	3
Stools have a foul odor	0	1	2	3
Suspect nutrient malabsorption	0	1	2	3
Diagnosed with Celiac Disease, Irritable Bowel Syndrome (IBS), diverticulosis/diverticulitis	0	1	2	3
Stomach cramps	0	1	2	3
Flatulence (gas)	0	1	2	3
Fiber-rich diet doesn't stop constipation	0	1	2	3
History of pimples, skin eruptions?		N	Y	=6
Any known food allergies?		N	Y	=6

Small Intestine total: _____

Green 0-10	Yellow 11-24	Red 25-45

Colon				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing gas or stool	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or buildup of debris on tongue	0	1	2	3
Use laxatives	0	1	2	3
History of bladder and/or kidney infection	0	1	2	3
Yeast infection (including vagina)	0	1	2	3
Fingernail and/or toenail fungus	0	1	2	3
Use of antibiotics in past year		N	Y	=6
			Colon total: _____	

Green 0-9	Yellow 10-24	Red 25-36

Leaky Gut (Intestinal Permeability)				
Adverse reactions to foods	0	1	2	3
Unpredictable food reactions	0	2	4	6
Aches, pains, and swelling throughout your body	0	1	2	3
Food allergies	0	2	4	5
Frequent bloating and distention after eating	0	1	2	3
			Leaky Gut total: _____	

Green 0-7	Yellow 8-15	Red 16-24

Hypothyroid				
Tired or sluggish	0	1	2	3
Feel cold (hands, feet, or your whole body)	0	1	2	3
Require an excessive amount of sleep to function properly	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression or lack of motivation	0	1	2	3
Thinning of the outer third of eyebrows	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dry skin and/or scalp	0	1	2	3
Slow brain processing	0	1	2	3
Lack of or diminished sex drive	0	1	2	3
Infertility or impotency		N	Y	=4
Heavy or profuse menstrual bleeding (women only)	0	1	2	3
			Hypothyroid total: _____	

Green 0-11	Yellow 12-22	Red 23-40

Hyperthyroid				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse, even at rest	0	1	2	3
Nervous or emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Eyes appear bulging or swollen	0	1	2	3
Difficulty gaining weight	0	1	2	3
			Hyperthyroid total: _____	

Green 0-5	Yellow 6-10	Red 11-24

Mitochondrial Dysfunction				
History of previous infections (EBV, Lyme, etc.)		N	Y	=6
Dizziness on standing up quickly	0	1	2	3
Unable to tolerate much exercise	0	1	2	3
Poor exercise or muscle stamina	0	1	2	3
Low muscle tone?		N	Y	=6
Brain fog	0	1	2	3
Difficulty focusing	0	1	2	3
Vision or hearing problems	0	1	2	3
General or chronic fatigue	0	1	2	3
Afternoon headaches	0	1	2	3
Migraines or seizures	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Blood sugar issues	0	1	2	3
Breathing problems	0	1	2	3
Overweight?		N	Y	=4
Low body temperature	0	1	Y	4
Intolerant to heat	0	1	2	3
Low thyroid lab numbers?		N	Y	=4
Little or no skin sweating?		N	Y	=4
Lack of digestive juices or undigested food	0	1	2	3
Leaky gut?		N	Y	=4
Suppressed immune system?		N	Y	=4
Catch colds or get sick easily?		N	Y	=4
SIBO or gut dysbiosis?		N	Y	=4
Reflux	0	1	2	3
Allergies	0	1	2	3
Food intolerances or sensitivities?		N	Y	=4
Chronic inflammation	0	1	2	3
Cannot fall asleep	0	1	2	3
Cannot stay asleep	0	1	2	3
Slow mover in the morning (hard to get day going)	0	1	2	3
Wake up tired, even after 6 or more hours of sleep	0	1	2	3
Weak nails	0	1	2	3
Eyes sensitive to bright or direct light	0	1	2	3
Weight gain when under stress	0	1	2	3
Loss of libido		N	Y	=4

Mitochondrial Dysfunction total: _____

Green 0-16	Yellow 17-50	Red 51-126

Drainage Dysfunction Susceptibility				
Constipation (pooping one or fewer times daily)	0	1	2	3
Feel full while eating and after meals	0	1	2	3
Diminished appetite	0	1	2	3
Feeling that bowels do not empty completely	0	1	2	3
General or chronic fatigue	0	1	2	3
Mood problems: anxiety, depression, or bipolar	0	1	2	3
Poor brain processing (cognition)	0	1	2	3
Chronic inflammation	0	1	2	3
Wake up between 1 a.m. - 4 a.m.	0	1	2	3
Edema or swelling	0	1	2	3
Skin problems, rashes, itches, hives, eczema, or acne	0	1	2	3
Yellowish skin, face	0	1	2	3
Suppressed immune system	0	1	2	3
Can't clear infections, despite pathogen protocols	0	1	2	3
Soreness or swollen breast tissue	0	1	2	3
Heart palpitations or irregular heartbeat	0	1	2	3
Light, sound, or EMF sensitivities	0	1	2	3
Morning stiffness	0	1	2	3
Brain fog	0	1	2	3
Swollen glands	0	1	2	3
Cellulite or flabby skin	0	1	2	3
Varicose or spider veins	0	1	2	3
Kidney problems	0	1	2	3
Breathing or lung issues	0	1	2	3
Skin doesn't sweat	0	1	2	3
Retain extra fluids	0	1	2	3

Drainage Dysfunction Susceptibility total: _____

Green 0-14	Yellow 15-35	Red 36-78

Minerals & Electrolytes				
Edema (swelling) in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Unable to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3
History of carpal tunnel syndrome		N	Y	=4
History of lower right abdominal pains or ileocecal valve problems		N	Y	=4
History of stress fracture		N	Y	=6
Bone loss (reduced density on bone scan)	0	1	2	3
Crave chocolate	0	1	2	3
Feet have a strong odor	0	1	2	3
History of anemia	0	1	2	3
Whites of eyes (sclera) are blue-tinted	0	1	2	3
Hoarse voice	0	1	2	3
White spots on fingernails	0	1	2	3
			Minerals & Electrolytes total: _____	

Green 0-19	Yellow 20-35	Red 36-59

CAUSES PARASITE INFECTION

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:
0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Parasite Infection				
Restless sleep (toss, turn, or wake often)	0	1	2	3
Skin issues, rashes, itches, hives, eczema, or acne	0	1	2	3
Frequent diarrhea or loose stools	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
SIBO (small intestinal bacterial overgrowth), feel bloated or gassy	0	1	2	3
Bowel urgency, occasional accidents	0	1	2	3
Abdominal pains, cramps, or burning	0	1	2	3
Rectal, anal itch	0	2	4	6
Anal fissures (small, painful tears or cracks)	0	2	4	6
Gut ulcers, sores, or lesions	0	1	2	3
Grinding of teeth when asleep	0	2	4	6
Picking at nose, boring nose with finger	0	2	4	6
Excess boogers in nose and scab-like boogers	0	2	4	6
Fingernail Biting	0	1	2	3
Vertical wrinkles around mouth	0	1	2	3
Parallel lines (tracks) in soles of feet	0	1	2	3
Irritable (no apparent reason)	0	1	2	3
Mood disorder, depression, anxiety, or suicidal thoughts	0	1	2	3
Hyperactive tendency (nervous)	0	1	2	3
Dark circles under eyes	0	2	4	6
Need for extra sleep, wake unrefreshed	0	1	2	3
Allergies and/or food sensitivities	0	2	3	4
Fevers of unknown origin	0	1	2	3
Night sweats (not menopausal)	0	1	2	3
Kiss pets, allow pets to lick your face	0	1	2	4
Increase of symptoms around a full moon	0	2	6	8
Anemia (low iron/hemoglobin on blood test)	0	1	2	4
Iron deficiency	0	2	4	6
Vitamin B6 deficiency	0	2	4	6
Zinc deficiency and/or white spots on nails	0	2	4	6
Frequent colds, flu, sore throats	0	1	2	3
Go barefoot in garden or parks	0	1	2	4
Travel in developing nations	0	2	4	6
Eat pork products	0	1	2	3
Eat sushi, raw fish	0	2	4	6
Sleep with pets on bed	0	1	2	3
Bed-wetting	0	1	2	3
Sexual dysfunction	0	1	2	3
Forgetfulness	0	1	2	3
Slow reflexes	0	1	2	3
Loss of appetite	0	1	2	6
Hungry all the time, bottomless pit, hungry after meals	0	2	4	6
Strong sugar and processed food cravings	0	1	2	3
Yellowish skin, face	0	1	2	3
Rapid heartbeat	0	1	2	3
Heart, chest pain	0	1	2	3
Breathing problems, asthma	0	2	4	6
Pain in belly button area (umbilicus)	0	1	2	4
Blurry, unclear vision	0	1	2	3
Eye floaters	0	2	4	6
Back, thigh, or shoulder pain	0	1	2	3
Lethargy, apathy (disinterest)	0	1	2	3
Numbness, tingling in hands, feet	0	1	2	3
Menstrual problems	0	1	2	3
Dry lips	0	1	2	3
Drooling while asleep	0	1	2	3
Occult blood in stool (from lab test)	0	1	2	3
Swim in creeks, rivers, lakes	0	2	4	6
History of Giardia, pin worms, worms, parasites?		N	Y	=6
Do you work in childcare?		N	Y	=6
History of or currently have cancer?		N	Y	=20
			Parasite Infection total: _____	
Green 0-46	**Yellow 47-96**	**Red 97-264**		

CAUSES RADIOACTIVE ELEMENTS

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Radioactive Elements				
History of or currently have cancer?		N	Y	=20
Suppressed immune system?		N	Y	=6
Osteoporosis or osteopenia diagnosis?		N	Y	=6
Can't clear infections, despite following pathogen protocols?		N	Y	=6
Chronic Candida infection	0	2	4	6
Fatigue	0	2	4	6
Anemia	0	2	4	6
Skin (red, dry, itchy, color changes)	0	1	2	3
Hair loss	0	2	4	6
Loss of appetite	0	1	2	3
Nausea and vomiting	0	1	2	3
Low blood cell count	0	1	2	3
Seizures	0	1	2	3
Earaches or difficulty hearing	0	1	2	3
Headaches	0	1	2	3
Memory or speech problems	0	1	2	3
Cranial nerve dysfunction	0	1	2	3
Hormone problems	0	1	2	3
Sore or dry mouth	0	1	2	3
Taste changes	0	1	2	3
Difficulty swallowing	0	2	4	6
Voice changes, hoarseness	0	1	2	3
Dry eyes	0	1	2	3
Stiff jaw	0	1	2	3
Tooth decay	0	1	2	3
Heartburn or indigestion	0	1	2	3
Chronic cough	0	1	2	3
Soreness or swelling of the breast	0	1	2	3
Heart palpitations	0	2	4	6
Irregular heartbeat	0	1	2	3
Bloating or gas	0	1	2	3
Diarrhea	0	1	2	3
Stomach ulcers	0	2	4	6
Kidney problems	0	1	2	3
Pain with bowel movements	0	1	2	3
Loss of bowel control	0	1	2	3
Bladder infection (cystitis)	0	2	4	6
Burning or pain during urination	0	1	2	3
Loss of bladder control	0	1	2	3
Fertility problems	0	1	2	3
Sexual problems (male & female)	0	1	2	3
Mental or emotional issues	0	1	2	3

Radioactive Elements total: _____

Green 0-16	**Yellow 17-40**	**Red 41-176**

CAUSES HEAVY METAL TOXICITY

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Mercury Toxicity				
Do you have amalgam (silver) fillings in your teeth?		N	Y	=20
Have you ever had an amalgam removed?		N	Y	=12
If you had amalgams removed, was it done by a biological dentist using a safe protocol?	N	=20	Y	=4
Were there amalgam fillings in your mother's mouth while she was pregnant with you?		N	Y	=3
Worked in a dental office?	0	1	2	3
Did you wear contact lenses during the 1980s or early 1990s?	0	1	2	3
Did you take oral contraceptives during the 1980s or early 1990s?	0	1	2	3
Have had flu shots	0	1	2	3
Have had allergy shots	0	1	2	3
Eat tuna, shark, swordfish or Atlantic Salmon more than twice per week	0	1	2	3
Urinate frequently (during the day, night, or both)	0	1	2	3
Sleep issues	0	1	2	3
Do you have compact fluorescent (CFL) bulbs in your home?		N	Y	=6
Have you broken any CFL bulbs?		N	Y	=12
Anxiety	0	1	2	3
Mood swings	0	1	2	3
Anger for no apparent reason	0	1	2	3
Excessive shyness, timidity, social phobia (not typical to your personality)	0	1	2	3
Irritability (not typical to your personality)	0	1	2	3
Dizzy or balance issues	0	1	2	3
Insomnia (can't get to sleep or return to sleep)	0	1	2	3
Low body temperature (below 97.5 degrees Fahrenheit or 36.4 degrees Celsius)	0	1	2	3
Sound in ears (ringing or hearing your heart beat)	0	1	2	3
Psychological symptoms, even thoughts of suicide	0	1	2	3
Sound sensitivities	0	1	2	3

Mercury Toxicity total: _____

Green 0-30	**Yellow 31-64**	**Red 65-130**

Lead Toxicity				
Have lived in a home built before 1978 using lead-based paint	0	2	4	6
Do home renovation, including sandblasting or moving walls	0	2	4	6
Currently live or previously lived in a mining community or area	0	2	4	6
Involved in construction, soldering, metal salvage, or stained glass	0	2	4	6
Are an electrician, handle electrical devices, electrical wiring, ballasts, or TV glass	0	2	4	6
Paint or handle/make ceramics, brass, bronze or crystal	0	2	4	6
Handle and/or reload ammunition	0	2	4	6
Read the newspaper regularly before 1985	0	2	4	6
Previously or currently consume a coral calcium supplement	0	2	4	6
Wear lipstick	0	2	4	6
Previously or currently wear cosmetics containing kohl (a dark pigment that is not FDA-approved for makeup)	0	2	4	6
Are around or have a lot of fake leather or vinyl	0	2	4	6
Get your hair colored	0	2	4	6
Get stomachaches in the morning?	0	2	4	6
Eyelid swelling	0	1	2	3
Eyelid twitching	0	1	2	3
Chest or heart pain	0	1	2	3
Metallic taste in mouth	0	1	2	3
Teeth sensitivity	0	1	2	3
Bleeding gums	0	1	2	3
Bad breath	0	1	2	3
Inability to decide/indecisiveness	0	1	2	3
Overwhelmed or fearful feeling	0	1	2	3
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Peeling of top layer of skin (hands, feet)	0	1	2	3
Dry skin	0	1	2	3
Depression	0	1	2	3
Dyslexia or loss of your place while reading, even as a child	0	1	2	3
Gout (arthritic pain, especially in big toes)	0	1	2	3
Pain in shoulders or upper back	0	1	2	3
Wrist or ankle drop, weak extensor muscles		N	Y	=6
Hair falls out (not normal male pattern baldness)		N	Y	=12
Lead Toxicity total: _____				
Green 0-37	**Yellow 38-70**		**Red 71-150**	

CAUSES LYME DISEASE

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Biotoxin Illness				
Shortness of breath with minimal activity	0	1	2	3
Excessive exhaustion after exercising	0	1	2	3
Excessive thirst	0	1	2	3
Morning stiffness	0	1	2	3
Irritated or red eyes	0	1	2	3
Non-restful sleep	0	1	2	3
Sensitive to light	0	1	2	3
Bad night vision or seeing halos around lights	0	1	2	3
Vision blurry	0	1	2	3
Sensitive to smells	0	1	2	3
Chronic fatigue or weakness	0	1	2	3
Biotoxin Illness total: _____				
Green 0-9	**Yellow 10-20**		**Red 21-33**	

Lyme Disease Risks				
Ever diagnosed with Lyme Disease?		N	Y	=10
Dry sockets or infected tooth extractions	0	1	2	3
Ever bitten by a tick?		N	Y	=6
Ever had a bullseye rash on any part of your body?		N	Y	=8
Mother ever diagnosed with Lyme Disease?		N	Y	=6
Spouse/partner/significant other diagnosed with Lyme Disease?	0	2	4	6
Ever diagnosed with chronic fatigue syndrome, fibromyalgia, lupus, rheumatoid arthritis (RA), multiple sclerosis (MS), or an Autoimmune condition?		N	Y	=6
Ever diagnosed with Parkinson's disease, Alzheimer's disease, or Tourette's Syndrome?		N	Y	=6
Frequently go camping, hunting, or engage in outdoor activities?		N	Y	=4
History of a heart murmur or valve prolapse		N	Y	=4
Lyme Disease Risk total: _____				
Green 0-9	**Yellow 10-18**		**Red 19-59**	

Lyme Disease Current Symptoms				
Arthritis-like joint pain or swelling	0	2	4	6
Pain migrates or moves around to different areas?	0	2	4	6
Forgetfulness or poor short-term memory	0	2	4	6
Confusion, difficulty thinking	0	1	2	3
Disorientation (getting lost; going to wrong places)	0	1	2	3
Difficulty with speech or writing	0	4	6	8
Tingling, numbness, burning, or stabbing sensations	0	4	6	8
Disturbed sleep: too much, too little, early awakening	0	2	4	6
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change (loss or gain)	0	1	2	3
Difficulty swallowing	0	1	2	3
Fatigue, lack of energy	0	1	2	3
Sore throat or swollen glands	0	1	2	3
Pelvic or testicular pain	0	4	6	8
Crepitus (joint cracking)	0	4	6	8
Stiff neck	0	2	4	6
Twitching of facial or other muscles	0	1	2	3
Muscle pain or cramps	0	1	2	3
Costochondritis (sternum/breastbone and rib junction pain)	0	4	6	8
Right shoulder pain (AC joint)	0	1	2	3
Facial paralysis (Bell's palsy)	0	4	6	8
Unexplained menstrual irregularity	0	4	6	8
Unexplained breast milk production	0	4	6	8
Irritable bladder or bladder dysfunction	0	4	6	8
Sexual dysfunction or low libido	0	4	6	8
Blurry or double vision	0	1	2	3
Ear buzzing, ringing, or pain	0	1	2	3
Vertigo or increased motion sickness	0	4	6	8
Light-headedness, poor balance, difficulty walking	0	4	6	8
Woozy (mentally unclear or hazy)	0	2	4	6
Tremors	0	2	4	6
Headaches	0	1	2	3
Impulsivity, aggression, or bipolar	0	1	2	3
Depression	0	1	2	3
Hallucinations, paranoia, or schizophrenia	0	2	4	6
Panic attacks	0	1	2	3
Eating disorder	0	4	6	8
Pulse skips	0	4	6	8
Skin hypersensitivity	0	2	4	6
Gastrointestinal problems	0	4	6	8
Change in bowel function	0	4	6	8
Exaggerated symptoms or worse hangover from alcohol	0	4	6	8

Lyme Disease Current Symptoms: _____

Green 0-31	Yellow 32-95	Red 96-238

CAUSES BABESIA

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Babesia				
Abdominal pain	0	2	4	6
Air hunger (episodes of breathlessness)	0	4	8	10
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Back stiffness	0	1	2	3
Chills	0	1	2	3
Cough	0	1	2	3
Depression	0	1	2	3
Diarrhea	0	2	4	6
Disturbed sleep: frequent waking	0	4	6	8
Excessive sleepiness	0	1	2	3
Exaggerated changes in mood	0	1	2	3
Encephalopathy (brain malfunction, brain issues)	0	1	2	3
Fatigue, tiredness, poor stamina	0	1	2	3
Fevers	0	1	2	3
Headaches	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Enlarged liver	0	2	4	6
Imbalance	0	2	4	6
Joint stiffness	0	1	2	3
Joint pain or swelling	0	1	2	3
Generalized ill feeling	0	1	2	3
Muscle pains or cramps	0	1	2	3
Nausea, vomiting	0	2	4	6
Neck stiffness, pain	0	1	2	3
Night sweats	0	1	2	3
Poor appetite	0	2	4	6
Shaking chills	0	4	6	8
Shortness of breath	0	1	2	3
Enlarged spleen	0	1	2	3
Tachycardia	0	1	2	3
Heart palpitations, pulse skips	0	4	6	8
Unexplained fevers, sweats, chills, or flushing	0	2	4	6
Dark urine with or without blood	0	4	6	8
Weakness	0	1	2	3
Weight loss	0	1	2	3
Lymph gland swelling	0	1	2	3
Anxiety or panic attacks	0	1	2	3
Depression	0	1	2	3
Low white blood cell count on labs	0	1	2	3
Low platelet count on lab test	0	1	2	3
Elevated sedimentation (sed) rate on labs	0	1	2	3
Dizziness	0	1	2	3
Feeling spacey	0	1	2	3

Babesia total: _____

Green 0-29	**Yellow 30-70**	**Red 71-180**

CAUSES BARTONELLA

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Bartonella				
Abdominal pain	0	2	4	6
Anemia (low iron/hemoglobin on blood test)	0	1	2	3
Anxiety	0	2	4	6
Back stiffness	0	1	2	3
Chills	0	1	2	3
Disturbed sleep: too much, too little, fractionated, early awakening	0	1	2	3
Ear buzzing, ringing, pain, sound sensitivity	0	2	4	6
Brain dysfunction	0	1	2	3
Hemolysis (destruction of red blood cells)	0	2	4	6
Endocarditis	0	2	4	6
Myocarditis	0	2	4	6
Fatigue, tiredness, poor stamina	0	1	2	3
Low-grade fever	0	2	4	6
Headaches	0	1	2	3
Enlarged liver	0	2	4	6
Immune deficiency	0	2	4	6
Feeling of coming down with the flu	0	2	4	6
Insomnia	0	1	2	3
Jaundice (yellowing of skin)	0	4	6	8
Joint pain or swelling	0	1	2	3
Lymph nodes swollen	0	4	6	8
Generalized ill feeling	0	1	2	3
Muscle pains or cramps, especially in calves	0	4	6	8
Foot pain or plantar fascitis-type pain (heels or soles of the feet)	0	4	6	8
Stretch mark-like rash (not from overweight)	0	6	8	12
Maculopapular rash (small red bumps)	0	4	6	8
Spider veins	0	2	4	6
Seizures	0	4	6	8
Sleepiness or drowsiness	0	2	4	6
Sore throat	0	2	4	6
Enlarged spleen	0	2	4	6
Shinbone pain	0	4	6	8
Tremors	0	2	4	6
Twitching of facial muscles	0	2	4	6
Upset stomach or abdominal pain	0	2	4	6
Weight loss	0	1	2	3
Eyes: blurred vision, red eyes, dry eyes, depth perception issue, light sensitivity	0	2	4	6
Anxiety, panic attacks, or excessive worry	0	2	4	6
Obsessive-compulsive disorder (OCD)	0	4	6	8

Bartonella total: _____

Green 0-29	Yellow 30-79	Red 80-223

CAUSES MOLD

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

Mold				
See mold growing at home, work, or school?		N	Y	=10
Ever experienced water damage at home, work or school?		N	Y	=4
Home, workplace or school has a damp or mildewy odor	0	1	2	3
Spending time in basement causes or worsens symptoms	0	1	2	3
Basement ever wet?		N	Y	=4
Symptoms decrease when spend time in a different location for at least a few days		N	Y	=4
Plumbing in your kitchen or bathroom leaks or has leaked in the past		N	Y	=4
Wet spots anywhere near your home (whether currently or past)		N	Y	=4
Often see condensation (fog) on the inside of windows and/or cold inside surfaces in your home		N	Y	=4
Car has a mildewy smell		N	Y	=4
Brain fog	0	1	2	3
Reactions to supplements opposite of expected	0	1	2	3
Nosebleeds	0	1	2	3
Body rashes	0	1	2	3
Any skin conditions		N	Y	=4
Does anyone in your home have asthma-like symptoms?		N	Y	=4
Sinus infections	0	1	2	3
One or more family members have chronic sinus infections or irritations	0	1	2	3
Runny, blocked, or stuffy nose	0	1	2	3
Experience static shocks	0	1	2	3
Wheezing or whistling in your chest	0	1	2	3
Wake up in the morning with a feeling of tightness in your chest	0	1	2	3
Wake up during the night with shortness of breath	0	1	2	3
Shortness of breath when you're not doing anything strenuous	0	1	2	3
Wake up during the night with an attack of coughing	0	1	2	3
Chest tightness when around animals or a dusty part of the house	0	1	2	3
Achy all over	0	1	2	3
Headaches	0	1	2	3
Extreme or unusual fatigue	0	1	2	3
Hoarse voice	0	1	2	3
Memory loss	0	1	2	3
Difficulty recalling names of people you know	0	1	2	3
Nausea	0	1	2	3
Vomiting	0	1	2	3

Mold total: _____

Green 0-19	Yellow 20-60	Red 61-118

CAUSES GENERAL TOXICITY

Instructions

Rate each of the following symptoms to the best of your ability based on the last **6 months**. For Yes/No answers, circle the number next to your answer (if there is a number). Total your score in the space provided. Compare your results with the rating system. A score in the yellow or red range suggests this area is more likely a problem for you.

POINT SCALE:

0 = Never 1 = Occasionally 2 = Often 3 = Regularly

General Toxicity				
Live on or near a golf course?		N	Y	=4
Live near a freeway or high-tension wires?		N	Y	=4
Wear conventional sunscreen?		N	Y	=4
Wear perfume or cologne?		N	Y	=4
Use air fresheners in your house, car, or workplace?		N	Y	=4
Were you the first-born child?		N	Y	=4
Receive static shocks (doorknob, car, light switch, other people, etc.)	0	1	2	3
Headaches or migraines	0	1	2	3
Word reversal or trouble finding words	0	1	2	3
Sensitivity to skin or touch	0	1	2	3
Poor short-term memory	0	1	2	3
Chronic sinus issues or congestion	0	1	2	3
Difficulty losing weight regardless of diet or exercise	0	1	2	3
Excessive perspiring during day or night	0	1	2	3
Cold extremities (hands and feet)	0	1	2	3
Issues processing new information	0	1	2	3
Chronic fungal or viral infection, including Candida, foot fungus, warts, or jock itch	0	1	2	3
Get sick often	0	1	2	3
Weakness or numbness in extremities	0	1	2	3
Joint pain	0	1	2	3
Muscle cramps, aches, sharp pains	0	1	2	3
Muscle twitching	0	1	2	3
Stomach pain	0	1	2	3
Appetite swings	0	1	2	3
Rashes or rosacea	0	1	2	3
General Toxicity total: _____				
Green 0-19	**Yellow 20-50**		**Red 51-81**	

COOPER
HEALTH SOLUTIONS

Are any of the following current or past occupations or hobbies?

❑ Agricultural product handler	❑ Firing Range operator	❑ Painter – Fine art
❑ Asbestos abatement technician	❑ Fisherman	❑ Pharmaceutical worker
❑ Auto mechanic	❑ Fluorescent tube manufacturer	❑ Plastic product manufacturer
❑ Battery manufacturer	❑ Foundry worker	❑ Plumber
❑ Battery recycler	❑ Glass manufacturing worker	❑ Plumbing supply manufacturer
❑ Canning plant worker	❑ Glassblower	❑ Policeman
❑ Carpenter	❑ Grinding operator	❑ Potter
❑ Ceramic manufacturer	❑ Hairdresser	❑ Preservative manufacturer
❑ Construction laborer or worker	❑ Hazardous material worker	❑ Printer
❑ Cosmetic manufacturer	❑ Ink manufacturer	❑ Search and rescue worker
❑ Cosmetologist	❑ Jeweler	❑ Ship repairer
❑ Dental Assistant	❑ Laboratory worker	❑ Shooting instructor
❑ Dynamite manufacturer or Dynamiter	❑ Landfill worker	❑ Smelting plant worker
❑ Electronic assembly worker	❑ Landscaper	❑ Solderer
❑ Electronic Component manufacturer	❑ Lumber processor	❑ Tanner
❑ Electroplater	❑ Lumber yard worker	❑ Tattoo artist
❑ Engraver	❑ Metal recycler	❑ Truck Mechanic
❑ Explosive expert	❑ Metal sculptor	❑ Waste Handler
❑ Fertilizer manufacturer	❑ Miner	❑ Welder
❑ Fiberglass installer	❑ Nail technician	❑ Well digger
❑ Fiberglass manufacturing worker	❑ Paint manufacturer	If you checked any of the above, you are at an increased risk of heavy metal toxicity.
❑ Firefighter	❑ Painter – Residential/commercial	

IN CASE OF EMERGENCY			
Name:	Relationship:	Home phone: ( )	Work phone: ( )

CLIENT ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I understand that I am here to learn about nutrition and better health practices, that I will be offered information about food supplements and herbs as a guide to general good health, and this is a personal ministry and spiritual counseling. I fully understand that those who counsel me are not medical doctors and I am not here for medical diagnostic purpose or treatment procedures. I am not on this visit, or any subsequent visit, an agent for federal, state, or local agencies or on a mission of entrapment or investigation. The services performed here are at all times restricted to consultation on nutritional matters intended for the maintenance of the best possible state of natural health, and do not involve the diagnosing, treatment or prescribing of remedies for disease. These statements have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat, cure, or prevent any disease.

If the Client needs to cancel or reschedule the appointment, the Client must do so 24 hours in advance; otherwise, the Client will forfeit that appointment and will not have an opportunity to reschedule it. An invoice for the appointment time will be sent to the Client for late cancellations or no shows if the appointment has not been prepaid. _____Client/Guardian initials

The Client will pay invoices upon receipt (the "Due Date"). If payment is not made when due, additional interest fees at a rate of 1.5% per month (18% annually) may be added until such time as all payments due have been made. A failure to make payment for a period more than 30 days from the due date of the payment shall be deemed a material breach of this Agreement. _____Client/Guardian initials

Client/Guardian signature *Date*