Authentic Eastern Health L.L.C

Iridology Analysis Client Form

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PERSONAL HEALTH PROFILE

Date: _____ Name: _____

Home Phone: _____ Work: _____ Cell: _____

When is the best time to call? _____ Call which phone? _____

May we leave a message? _____ Email: _____

Address: _____

Date of Birth: _____Age:_____ Weight: _____ Height: _____ Blood type: _____

Emergency Contact/Relationship: _____ Contact Phone: _____

Occupation: _____ Referred by: _____

Marital Status: _____

Spouse's Name: _____ Spouse's Occupation: _____

Living situation: people's names and relationship to you:

_____

_____

Do you have pets? _____what are they? _____

Name of Primary Care Doctor: _____

Other Health Care Practitioners: _____

PRESENT HEALTH CONCERNS:

1._____

2._____

3._____

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What do you hope to achieve with this visit? _____

Date of last physical? _____Physician's Diagnosis: _____

Physician's Treatment: _____

Other Health Practitioner's response:_____

Do you have any allergies or chemical sensitivities? _____

Please list any food allergies_____

Please list any allergies to medications: _____

Please list any medications taken regularly and explain for what reason you take them:

_____

_____

_____

_____

Please list any supplements or herbs taken regularly:

_____

_____

_____

_____

Please list any childhood illnesses & medications/vaccinations taken_____

_____

What is your favorite pastime? _____

Name two dominant emotions in your life now _____ & _____

Do you usually feel hot or cold? _____

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BODY SYSTEM HEALTH PROFILE
Please check any item listed below, rating it as follows:
1 = sometimes 2 = often 3 = major concern. Leave blank if not applicable.

Circulatory
__High Blood Pressure
__Low Blood Pressure
__Palpitations
__High Cholesterol
__High Triglycerides
__Varicose veins
__Spider veins
__Cold hands & feet
__Poor circulation
__Pain in Chest
__Previous heart attack or stroke
__Swelling in ankles/joints
__Anemia
__Dizziness
__Bruise easily
__Other:_____

Respiratory
__Allergies
__Asthma
__Sinus congestion
__Post Nasal Drip
__Sore throat
__Lung congestion
__Difficulty breathing
__Cough
__History of Tuberculosis
__Recurrent influenza
__Cold
__Sinus infection
__Other: _____

Eyes, Ears, Nose & Throat
__Eye pain, wet/dry
__Failing vision
__Ear aches
__Hearing loss
__Ringing in the ears/tinnitus
__Hay fever
__Tonsillitis
__ Other:_____

Digestive
__Mouth ulcers
__Halitosis – bad breath
__Hiatal hernia
__ Bloating
__History of Hepatitis
__Gall stones
__Hypoglycemia (low blood sugar)
__burping

Skin
__Boils
__Acne
__Eczema
__Psoriasis
__Herpes Simplex
__Slow wound healing
__Warts
__Moles
__Skin tags

__Ulcers
__Constipation
__Diarrhea

__Irritable bowel
__Polyps
__Hemorrhoids
__Bleeding from anus
__Flatulence/gas

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__Skin cancer
__Fungal, bacterial infections
__Other_____

__Reflux/regurgitation/GERD
__Nausea
__Other _____

Urinary
__Bladder infections
__Kidney stones
__Water retention/swelling of ankles/legs
__Incontinence
__Painful urination
__Excessive urination
__Do you get up at night to urinate? How often?
__Low back pain
__Blood in urine
__Other_____

Muscular/skeletal
__stiffness
__Bursitis
__Torn ligaments
__Backache – where?_____
__Broken bones – where?_____
__Arthritis – where? _____
__Restricted mobility
__Gout
__Sprains – where? _____
__Other_____

Reproductive (Women)
Any testing? _____
Are you pregnant now?_____
No. of Pregnancies carried to term _____ Date(s):_____
No. of Pregnancies not completed (miscarriage/abortion): ____date(s):_____
Contraceptive use: in past – types and how long_____
Currently: _____
Sexually transmitted diseases, list type if known:_____
Hysterectomy – Date: _____Reason: _____
Uterine fibroids_____
Ovarian cysts_____
Endometriosis_____

___Vaginal infection
___Breast pain
___Breast lumps
___Pelvic inflammatory disease
__Vaginal itching/discharge
__Infertility

__Genital herpes
__Cervical dysplasia
__Painful intercourse
__Vaginal dryness
__Uterine prolapsed
__Other

Menstruating Women
__Irregular cycle
__Heavy menstrual bleeding
__Painful menstrual cramps
__Bleeding between cycles
__Absence of menstrual cycle
__Dramatic mood swings before cycle
__Lack of sex drive
How long between periods? _____
Describe flow:_____

Menopausal Women
__Hot flashes
__Dramatic mood swings
__Vaginal dryness
__Osteoporosis
__Vaginal bleeding
__ HRT
__Lack of sex drive

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Reproductive (Men)

__Impotence
__Sexually transmitted disease – list type if known_____
__Prostatitis
__Premature ejaculation
__Lack of sex drive
__Low sperm count
__low sperm mobility
__Benign prostatic enlargement
__Other_____

Endocrine

__Pituitary
__Pineal
__Thyroid
__Pancreas
__Diabetes
__Hypoglycemia
__Other_____

Lymphatic

__Congestion
__Swollen glands
__Infection
__Other_____

Nervous System

__Anxiety
__Irritability
__Stress
__Headaches
__Migraines
__Insomnia
__Depression
__Attention Deficient
__Hyperactivity
__Mental sluggishness
__Poor memory
__Shingles
__Other _____

Immune System

__Auto-immune disease
__Chronic Fatigue Syndrome
__Frequent colds
__Chronic infection, i.e. HPV, HIV, Herpes, tooth infections

Past Medical History

Please list any operations that you have had w/approx. date (tonsillectomy, appendectomy, implants, etc)_____

Please list any major injuries/accidents, including date:

_____

Please list any traumatic experiences not medically treated (divorce, loss of job, death of loved one, etc) :

_____

Family Medical History: _____

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Maternal Medical History

_____

Paternal Medical History

_____

Sibling Medical History

_____

_____

Common Physical Activities

Diet

Typical day

Breakfast:_____

_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you crave anything? (Sweet, salty, pizza, alcohol, etc)_____

Food Category	**Food Use Frequency**	**Comments**

0 = never eat 1 = sometimes 2 = often 3 = often Leave blank if not applicable.

____ Red Meat ____ Poultry ____ Fish ____ Dairy (milk, cheese, yogurt)
____ Eggs ____ Fried Foods ____ Sugar ____ Alcohol
____ Coffee/caffeine ____ Soda/diet soda ____ Water ____ Tobacco
____ Whole grains ____ White flour products ____ Vegetables ____ Fruits ____ Beans

Printed Name: _____

Signature: _____

Date: _____

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CONSENT FOR SERVICES

I, _____hereby attest and agree to the following:

1) I fully understand that Ping Jian Zhao is a lay natural health advisor who deals strictly in helping people to improve their general health and fitness through better nutrition, improved lifestyle, health habits, and positive mental attitudes.

2) I fully understand that Ping Jian Zhao is not a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatment for specific disease conditions.

3) I understand that all evaluations analysis performed by Ping Jian Zhao or her representatives are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits and attitudes. I further understand that said evaluations cannot determine specific disease conditions I may have and do not replace the diagnostic services offered by licensed physicians.

4) I understand that Ping Jian Zhao neither claims nor implies that any instruction, advice, counsel, suggestions, recommendations, services or products she or her representatives provide, whether in person or by mail or by telephone, will cure, treat, prevent or mitigate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural function of body systems and otherwise improving general health and fitness.

5) I certify that Ping Jian Zhao or her representatives have not suggested that I cease any medical care I may be undertaking. I understand that the decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Ping Jian Zhao or her representatives responsible for the consequences of my decisions.

6) I certify that I am here on this visit and on any subsequent visit or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county or local government or private agency on a mission of investigation.

I have read and understand the foregoing and agree to the terms and conditions set therein. I also acknowledge that I am making a personal choice to receive educational sessions with Ping Jian Zhao, a Naturopathy Consultant. I understand that it is also my personal choice to act, or not, on any of the recommendations provided.

Date _____ Referred by: _____

Client Signature: _____

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CANCELLATION and RETURN POLICY

Authentic Eastern Health, LLC requires 24-hour notice of cancellation prior to scheduled appointments. I hereby agree to pay $25 to Authentic Eastern Health L.L.C in the event I do not comply with this 24-hour cancellation policy.

If I am late for my appointment, my time may be cut short in order to keep other people on schedule.

Any return of herbal supplement products should be in the original sealed package and within 30 days.

Print Name: _____

Signature: _____ Date: _____

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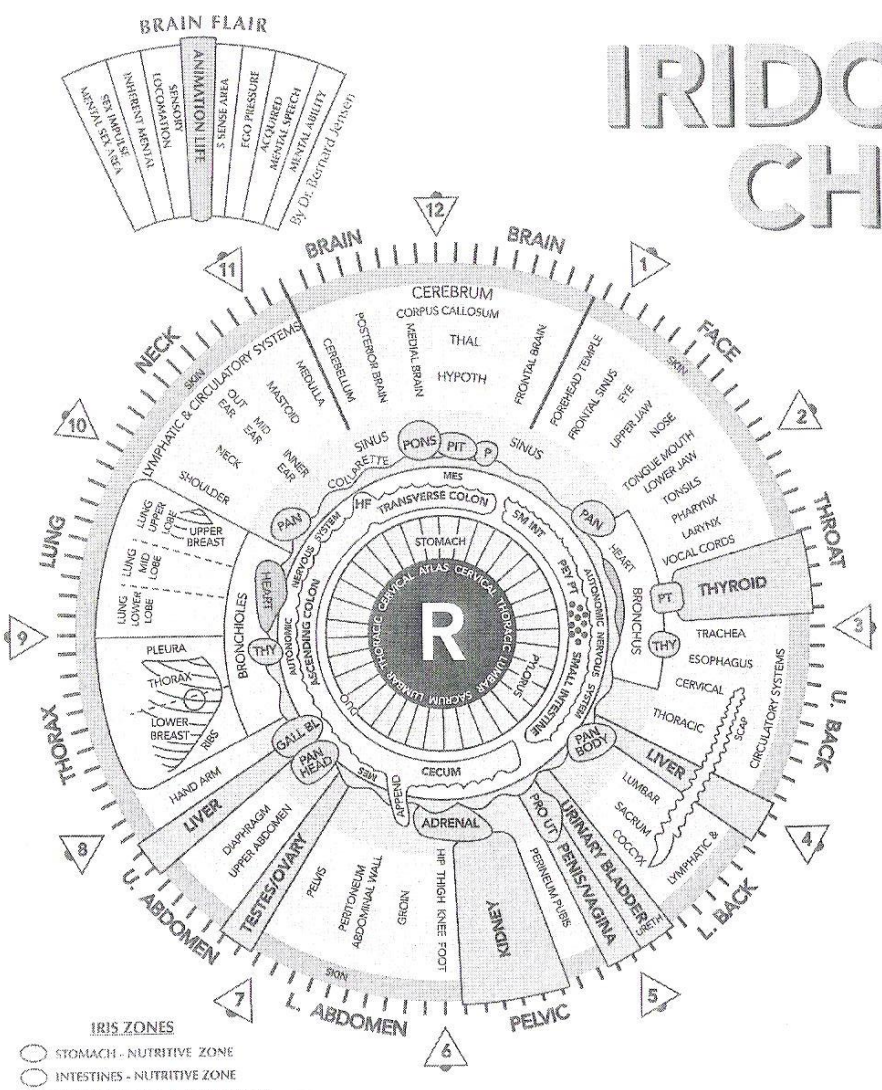
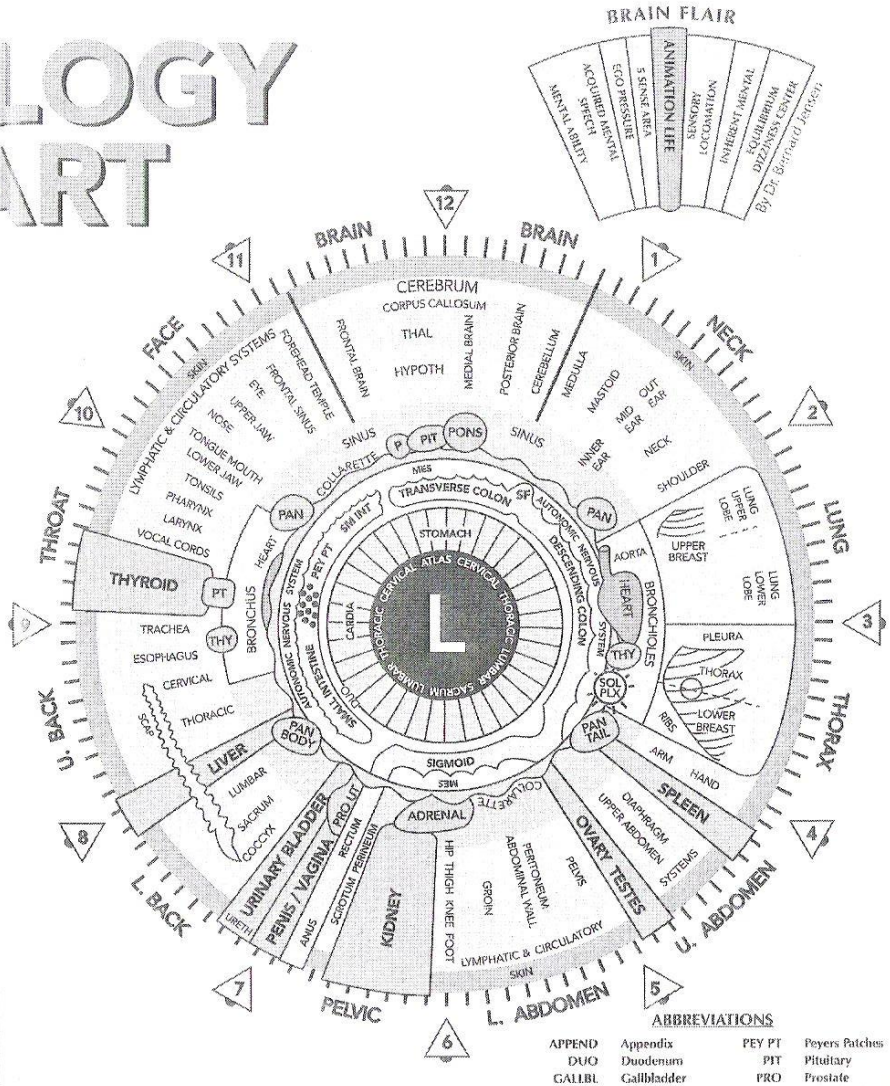
IRIDOLOGY CHART





IRIS ZONES

- STOMACH - NUTRITIVE ZONE
- INTESTINES - NUTRITIVE ZONE
- BLOOD & LYMPH - HUMORAL ZONE
- MUSCULATURE
- BONY STRUCTURE
- SUPERFICIAL LYMPH & BLOOD
- SKIN & ORIFICES

CILLARY ZONE

ABBREVIATIONS

APPEND	Appendix	PEY PT	Peyers Patches
DUO	Duodenum	PIT	Pituitary
GALLBL	Gallbladder	PRO	Prostate
HF	Hepatic Flexure	SF	Spleenic Flexure
HYPOTH	Hypothalamus	SCAP	Scapula
MES	Mesentery	SOL PLX	Solar Plexus
P	Pineal	THAL	Thalamus
PT	Parathyroid	THY	Thymus
PAN	Pancreas	URETH	Urethra

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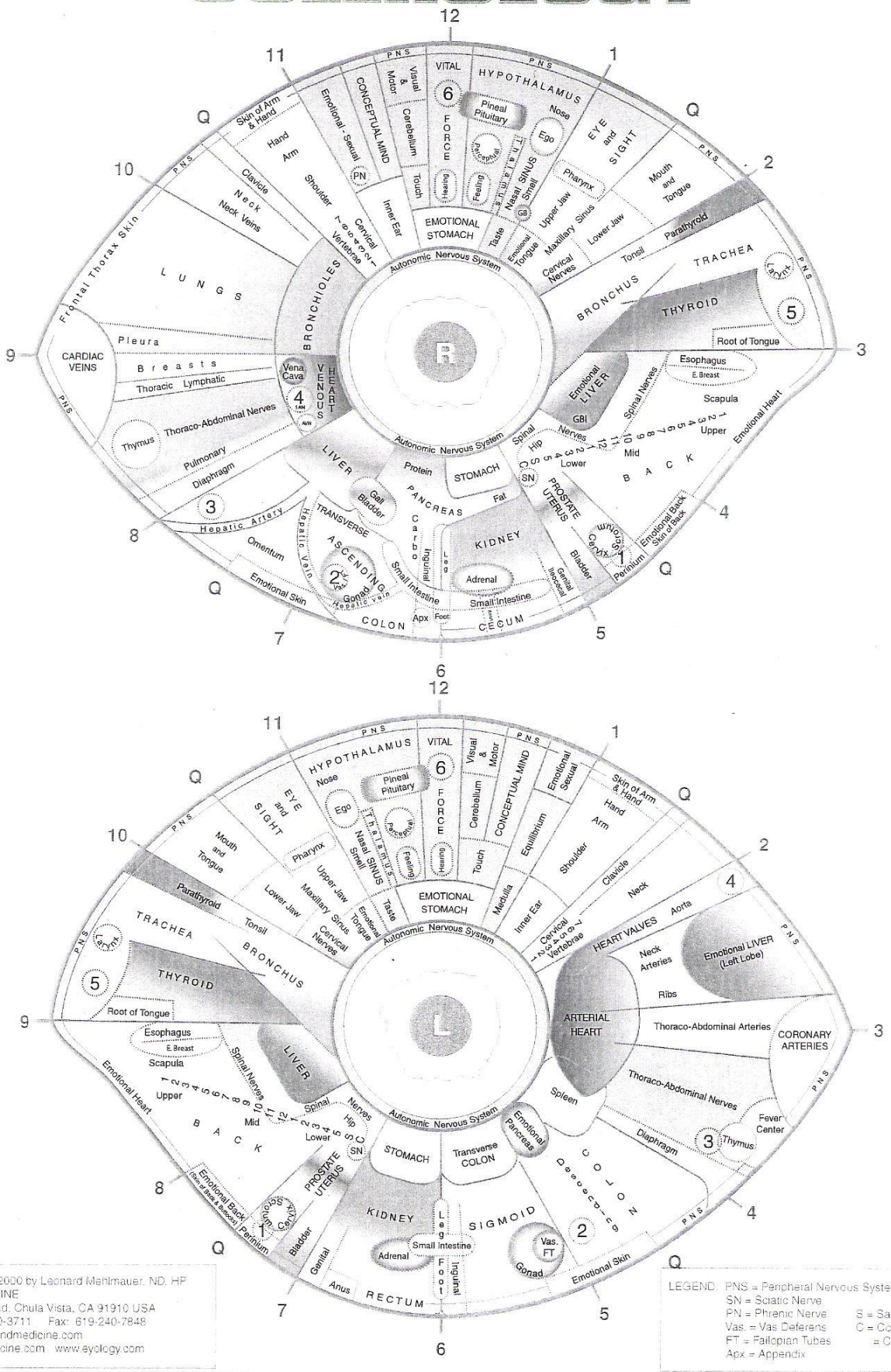
Iridology Analysis Client Form v4.1

SCLEROLOGY



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LEGEND: PNS = Peripheral Nervous System
SN = Sciatic Nerve
PN = Phrenic Nerve S = Sacrum
Vas. = Vas Deferens C = Coccyx
FT = Fallopian Tubes = Chakra points
Apx = Appendix

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