Ron Schaefer
Certified Holistic Iridologist
EyesByRon.com

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Client Intake Form

Please Print Clearly

Name:		**Ht:**	**Wt:**	**Age:**
Address:		**D.O.B.:**		
City:		**State:**		**Zip:**
Phone #	**Work #**	**Cell #**		
Family Physician:				

What is your body telling you?

Yes	No	GASTRO-INTESTINAL TRACT
		Is your tongue coated (white, yellow, green or brown), especially in the A.M.?
		Do you have a Hiatus Hernia?
		Do you have Gastritis?
		Do you have Enteritis?
		Do you have Colitis?
		Do you have Diverticulitis?
		Do you get or have Diarrhea?
		Do you get or have Constipation?
		How often do you have a Bowel Movement?
		Have you ever had Stomach or Intestinal Ulsers?
		Do you or have you ever had any type of Gastro-intestinal Cancers? (Stomach, colon, rectal, etc.) Explain:
		Do you have Chrohn's Disease?
		Do you have "gas" problems?
		Other GI problems:
		Does your stomach always have a queezy feeling?
		Does your stomach get upset after a meal or certain meals?
		Can you eat a big breakfast without getting an upset feeling?

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Yes	No	LIVER / GALLBLADDER / BLOOD
		Do you have a problem digesting fats?
		Do fats or dairy foods cause bloating and/or pain in the stomach area?
		Are your stools white in color?
		Are your stools light brown in color?
		Do you get pain in the middle of your back (especially after eating)?
		Do you get pain behind the right, lower rib area?
		Do you have "liver" or brown spots on your skin? (Not freckles)
		Do you have any skin pigmentation changes?
		Do you have any skin problems? If so, what type?
		Are you anemic?
		Do you have, or have you ever had, hepatitis? A: B: C:

Yes	No	THYROID / PARATHYROID (Glandular System)
		Are you over weight?
		Do you get cold hands or feet?
		Do you have hair loss or are you bald or loose it?
		Is it easy to put on weight and hard to loose it?
		Are your fingernails ridged, brittle or weak?
		Do you have varicose or spider veins?
		Do you or have you had hemorrhoids?
		Do you get cramping in your muscles?
Strong	Weak	Is your bladder strong or weak?
		Do you have an irregular heartbeat?
		Do you have Mitral Valve Prolapse (Heart Murmur)?
		Do you get headaches or migraines?
		Do you now have, or have you ever had a hernia?
		Have you ever had an aneurysm?
		Do you have osteoporosis?
		Do you have scoliosis?
		Do you get irritable easily?
		Do you have low energy levels?
		Do you suffer from symptoms of depression?

		Have you had your Calcium levels checked? If so, do they show Low: _____ Normal: _____ High: _____
		Do you have, or have you ever had a Goiter?
		Do you have spine deterioration, herniated discs, or bone spurs?
		Have you ever been diagnosed with Hashimoto or Reidel disease?
		How much do you sweat? Low: ____ Medium: _____ Excessive: _____
		Do your legs get tired or cramp after you walk?
		Do you bruise easily? (Parathyroid)

Yes	No	PANCREAS
		Do you get gas after you eat?
		Do you feel your foods just sitting in your stomach?
		Do you get acid reflux?
		Do you get undigested foods in your stool?
		Are you thin and have a hard time putting on weight?
		Do your foods pass right through you? (Diarrhea)
		Do you have moles on your body? (Adrenal & Pancreatic weakness)

Yes	No	FEMALES ONLY
		Are your menstruations irregular? (Pituitary)
		Do you get excessive bleeding during menstruation?
		Do you have or have you had ovarian cysts?
		Do you have or have you had fibroids?
		Do you have or have you had endometriosis or A-typical cells?
		Do you have or have you had fibrocystic breasts?
		Do you get sore breasts, especially during menstruation?
		Do you have a low or excessive sex drive?
		Have you had a hysterectomy? Date: _____ Was it: Partial: _____ Complete: _____
		Did they take any other organs out at the same time? (ex: Gallbladder) If yes, what other organs?
		Have you had a miscarriage?
		Have you had difficulty conceiving children?
		Have you been on birth control pills? If so, how long?
		Are you currently pregnant?

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Yes	No	MALES ONLY
		Do you have prostatitis? (frequent urination especially at night) If yes, how often do you urinate>
		Do you have prostate cancer? If so, what are your PSA courts? _____ Date: _____
		Do you have testicular hypertrophy? (enlargement)
		Do you have a low or excessive sex drive?
		Do you have erection problems?
		Do you have premature ejaculation? Other:

Yes	No	HEART AND CIRCULATON
		Do you get chest pains or angina?
		Have you ever had a heart attack? (Myocardial Infarction)
		Have you ever had open heart surgery?
		Do you have heart arrhythmias? What kind?
		Do you have a heart murmur or Mitral Valve Prolapse?
		Do you feel pressure in your chest?
		Do you get "prickly" pains anywhere, especially in your heart area? Where?
		Do you have, or have you ever had High Blood Pressure? (kidneys)
		Do you have a pacemaker? _____ Or Stents? _____

Yes	No	ADRENAL GLANDS (Glandular System) Medulla (Adrenal)
		Are you over weight?
		Do you have? Parkinson: _____ M.S: _____ Palsy: _____
		Do you have anxiety attacks, or feel overly anxious?
		Do you feel excessive shyness or inferior to others?
		Do you have tremors, nervous legs, jittery, etc.?
		Do you have High:_____ or Low:_____ Blood Pressure? Systolic: _____ Diastolic: _____
		Do you have hypoglycemia (low blood sugar)?

		Do you have Diabetes (high blood sugar)? If yes, Type 1: _____ or Type 2: _____
		Do you have tinnitus (ringing in the ears)?
		Do you have Shortness of Breath or is it hard to take a deep breath?
		Do you have heart arrhythmias?
		Do you have a hard time sleeping or insomnia? (pineal gland)
		Do you have Chronic Fatigue Syndrome?
		Have you ever been diagnosed with Addison's Disease?
		Have you ever been diagnosed with Congenital Hyperplasia?

Yes	No	**CORTEX (Adrenal)**
		Do you have elevated blood cholesterol levels?
		Do you have "itis's" (inflammatory issues)? (Arthritis, bursitis, rheumatoid arthritis, colitis, enteritis, phlebitis, neuritis, etc.)
		Do you have any low steroids or cortisol levels?

Yes	No	**SKIN**
		Do you get or have skin rashes?
		Do you get skin blemishes?
		Do you have Eczema or Dermatitis?
		Do you have Psoriasis?
		Do you itch anywhere? Where?
		Is your skin dry?
		Is your skin excessively oily?
		Do you get or have dandruff?
		Do you have skin problems? Explain:

Yes	No	**LYMPHATIC SYSTEM**
		Do you have hair loss or are you bald or going bald?
		Have you ever had Lymph Nodes removed? Where:_____
		Do you have any gray hair?
		Do you have a hard time remembering things?
		Do you get cold or flu-like symptoms?

		Do you have fibromyalgia or scleroderma?
		Do you have sinus problems?
		Do you have or get sore throats?
		Do you have swollen lymph nodes?
		Do you have or have you had tumors? Where? What type: Fatty:_____ Benign: _____ Malignant:_____
		Do you have a low platelet count? (blood)
		Is your immune system weak or sluggish?
		Have you had appendicitis or an appendectomy? When?
		Do you get boils, pimples, cysts, etc?
		Do you get regular exercise? How many times per week?_____
		Have you ever had abscesses?
		Have you ever had toxemia?
		Do you have or have you had cellulitis?
		Have you ever had gout?
		Do you get blurred vision?
		Do you have mucus in your eyes when you wake up in the morning?
		Do you snore?
		Do you have sleep apnea?
		Have you had your tonsils taken out? What age?_____

Yes	No	**KIDNEYS and BLADDER**
		Have you ever had urinary tract infections? (UTIs)
		Have you ever had “burning” upon urination?
		Do you have problems holding your bladder? (parathyroid)
		Have you ever had kidney stones?
		Do you have bags under your eyes, especially in the morning?
		Is your urine flow restricted?
		Do you get cramping or leg pain on either side of your mid-to-lower back?
		Do you or did you ever have nephritis?
		Do you have lower back weakness?
		Do you have or ever had sciatica?
		Do you have or ever had cystitis?

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Yes	No	LUNGS
		Do you get or have had bronchitis?
		Do you get or have had emphysema?
		Do you get or have had asthma?
		Do you get or have had C.O.P.D.?
		Are you on inhalers or nebulizers? How often? What type? Oxygen saturation level:_____
		Do you get pain when you breathe?
		Do you get pain when you take a deep breath? (Adrenals)
		Is it difficult to take a deep breath?
		Did you ever or have you ever had lung cancer?
		Do you have a collapsed lung?
		Are you a smoker or toker? How many cigarettes per day?_____ Or packs per day?_____
		Have you ever had pneumonia?
		Have you ever worked around asbestos?
		Do you cough a lot?
		Do you ever get any mucus when you cough?
		What color is the mucus? (clear, yellow, green, brown, or black?):_____

Yes	No	ENVIRONMENTAL TOXINS
		Have you ever been vaccinated?
		Have you had flu shots for traveling to foreign countries?
		Have you ever had flu shots?
		Do you have mercury Amalgams?
		Do you get pain when you take a deep breath? (Adrenals)
		Have you been exposed to nuclear wastes, by-products, heavy metals or chemicals?
		Have you had radiation? _____ Or chemotherapy?_____ If so, how many treatments?

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(1) List any chemical medications you are presently taking:

Medication Name	Reason for Taking

(2) List any natural supplements you are presently taking:

Supplements:

(3) Allergies – List everything that you know you are allergic to:

Allergies:

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(4) Past Surgeries – List any past surgeries you have had, major or minor:

Surgeries:

(5) What is your genetic medical history?

Mother:	
Father:	
(Maternal) Grandfather:	
(Maternal) Grandmother:	
(Paternal) Grandfather:	
(Paternal) Grandmother:	
Sister:	
Sister:	
Sister:	
Brother:	
Brother:	
Brother:	

(6) What are your major health concerns or complaints?

Concerns: