

Iridology Client Intake Form

Today's Date _____

Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

E-mail Address _____ Would you like your assessment sent to you via e-mail? Yes _____ No _____

Are you under a physician's care now? _____ For What? _____

Primary Care Physician: _____

Current Occupation: _____ Hours worked per day: _____

Birth Date: _____ Height _____ Weight _____

Male _____ Female _____

What is your main complaint physically? _____

Surgeries: List type and approximate date and age:

Any Medically Diagnosed Diseases or Disorders:

Medications:

Name of Medication	What it is for	Dosage
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History of Disease or Medical Condition: _____

Genealogy Traits

Are you more similar to your mother or your father? Explain why: _____

Name _____ Date _____

Personal History:

Allergies: foods _____

Medication: _____

Pollens, pets, etc. _____

Have you ever had hepatitis? _____

Have you ever had a blood transfusion? _____

Do you smoke? _____ If yes, how many packs a day? _____ How long? _____

Have you quit smoking? _____ If yes, when? _____

Do you use alcohol? _____ How often? _____

Sleep: Hours per day _____

Exercise: _____

Females: check those that apply

___ You have menstrual cycles

___ You are in Menopause or peri-menopause?

___ You have ever taken Birth control meds. For How long? _____

___ You are pregnant now

___ Other problems

Number of pregnancies _____ Number of children _____

Males: Check those that apply

___ Prostate gland problems _____ Difficult urinating _____ Frequent Urination

___ Other problems (describe) _____

Complaints or Symptoms:

___ Fatigue

___ Depression

___ Poor Digestion

___ Memory Loss

___ Hearing Problems

___ Indigestion

___ Crave Sweets

___ Tire Easily

___ Vision Problems

___ Headaches

___ Constipation

___ Cold Hands/ Feet

___ Dizziness

___ Diarrhea

___ Burping/ Belching

___ Earaches

___ Hemorrhoids

___ Bloating/ Gas

___ Bowel Problems

___ Back problems

___ Swelling

___ Muscle Aches

___ Joint Pain

___ Abdominal Pain

___ Heart Problems

___ Skin Problems

___ Breathing Problems

___ Anxiety

___ Lack Patience

___ Nagging Cough

___ Nervousness

___ Shortness of Breath

___ Temper Problems

___ Hernias

___ Sinus Problems

___ Difficulty Sleeping

___ Varicose Veins

___ Sore Throat

___ Dental Problems

___ Low Blood Sugar

___ Bad Breath

___ Low Blood Pressure

___ Diabetes

___ Blood clots

___ High Blood Pressure

INFORMED CONSENT STATEMENT

I, _____ hereby attest and agree to the following:

- 1) I understand that all evaluations/analysis performed by Robin Proetta, DC 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 medical physicians.
- 2) I understand that Robin Proetta, DC 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.
- 3) I certify that Robin Proetta, DC 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 Robin Proetta, DC or her representative responsible for the consequences of my decisions.
- 4) I certify that I am here on this 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.

Date _____ Referred by: _____

Client Signature: _____