



HealthGuard 142™
Covid Injuries Diagnostics and Detox Healing Program

Let The True Healing Begin

PART ONE : GETTING TO KNOW YOU ...

Patient's Full Name

Membership

I am a BSI Member Patient

I am not yet a Member Patient

Contact

Profession(s)

Working Status

Working full or part

Retired

Not working

Self-employed

On vacation

Other, please comment

Present Patient Location

Email

Please choose where you want to see the BSI Doctor...

Canggu / Tibubeneng, Doctor Vincent, for all services

Ubud / Sanggingan, Doctor Steven, for all services

GWK / Jimbaran, Doctor Igo, for all services

GWK / Jimbaran, Doctor Mona, for all services

Nationality

When would you like to book an appointment ?

Referred by Whom

Please tell us what services you seek at BSI ...

Deep Dive Parasites & Diseases Testing & Remedies Service

- Rp. 5.500.000

Female Hormones Testing & Therapy, Testing & Diagnosis with Natural Therapies

- Rp. 7.700.000

Male Hormones Testing & Therapy, Testing & Diagnosis with Natural Therapies

- Rp. 7.700.000

Service Timing Parameters

I am in Bali for 6 weeks or more, and can receive full services (recommended).

I am in Bali for 3 weeks and can receive accelerated services, with remaining therapies taken home, with email counseling.

I am in Bali 1-2 weeks, and can begin services, with remaining therapies taken home, with email counseling.

I am in Bali for 3-4 business days, and can received initial testing and test results. Therapy will be taken when I return in less than 1 month.

I am in Bali for 1-2 business days, and can receive initial testing only. I can receive results via email, with email counseling in less than 1 week (Extra charge). Therapy will be taken when I return in less than 1 month.

I am in Bali for 1-2 business days, and can receive initial testing only. I can receive results via email, with on-line secure server video counseling for one hour, combined with subsequent email counseling. Video call must be taken in less than one week. (Extra charge). Therapy will be taken when I return in less than 1 month.

PART TWO : PATIENT VITAL INFORMATION ...

Are You Able to Care for Yourself, Able to Walk?

YES, I am able to care for myself and walk

NO, I am incapacitated.

Patient Gender

Biological male

Biological female

Different options

Present Age in Years

Faith, Religion, or Practice

Date of Birth

PART THREE : PATIENT REQUEST FOR SERVICES ...

Please Fully Describe the Illness or Concerns

Present Weight

Present Height

Blood Type (if known)

Blood Thalassemia

No, I do not have Thalassemia

Yes, I have Thalassemia

Hemophilia

No, I do not have Hemophilia

Yes, I have Hemophilia

Describe Your Exercise Habits

Type 0: Not much. Sedentary

Type 1: Occasional short walking, relaxation

Type 2: Yoga, Pilates, stretching, light to moderate swimming etc. Occasionally raise heart rate high

Type 3: Occasional or frequent running, jumping, trampoline, jogging (lymphatic stimulation and impact exercise)

Type 4: Weight lifting, muscle building, (endurance training)

Type 5: Super Athletic, trains or works out nearly daily.

Stress Level

1 (No or very little stress, easy going, content)

2 (Normal stresses of managing a home or local environs, but happy)

3 (Normal stresses of challenging work or relationship, could use more rest)

4 (Moderate work stresses, challenging emotions, a little cranky but coping)

5 (Moderate or higher stresses from disease and / or home life / work life, need time off but can't)

6 (Very stressed and emotional, need distance, occasional snapping / yelling at others)

7 (Mild anger or sadness much of the time. Work hard to avoid conflict with others, may be taking related medications)

8 (Outraged most of the time, depressed, nothing makes sense, over-saturated with surroundings and society, yelling or striking at others)

9 (No hope, no patience, beyond ability to be calm or relaxed, unable to sleep)

10 (Totally unable to function in the world, restrained from public contact, fully anti-social)

Time I normally go to bed

Time I normally awaken

Nap

I do not take naps

I nap (how many times per week)

I usually nap for how many minutes when I nap

Normal Sleep Habits

I am told I snore at night
I recover from jet lag with difficulty
I have difficulty falling asleep
I fall into a deep sleep
My sleep hours are enough
I feel vigorous after sleep
I am satisfied with my sleep
I have a clear head after sleep
I wake up while sleeping
I wake up easily because of noise
I have difficulty getting back to sleep once
I wake up in middle of the night
I toss and turn

I never go back to sleep after awakening during sleep
Poor sleep gives me headaches
Poor sleep makes me irritated
Poor sleep makes me lose my appetite
Poor sleep makes it hard for me to think
Poor sleep makes it hard to concentrate
Poor sleep makes me lose interest in work or others
Poor sleep makes me forget things more easily
Poor sleep makes me lose desire in all things
Sleepiness interferes with my daily life
I have difficulty getting out of bed
I would like to sleep more after waking up
I feel refreshed after sleep

Please comment here

PART FOUR : GENERAL HEALTH QUESTIONS ...

Usual Diet. Does the Patient Consume these Weekly or Daily?

Wheat products (bread, pasta, noodles etc.)
Sweet bakery items (donuts, cakes, cookies, etc.)
Sweets, candies, chocolate, etc. each day
Need to eat something sweet in or with most or all meals
Common junk foods, chips, cakes, candies, etc
Dairy products (milk, ice cream, cheese, yoghurt, etc.)
Soy products (tofu, tempeh, soy sauce, soy flour, etc.)
Processed, pre-packaged meats (canned meats of any kind, meat mixtures, bacon, lunch meats, sausage, etc.)
Consume boxed, canned, bagged, pre-made foods from super markets (cereals, frozen meals, etc.)
Low-grade fats, (oils of soy, canola, corn, highly processed oils, hydrolyzed shortening, etc.)
Juices, cold-pressed juices, smoothies, shakes, etc.
Powdered foods (spirulina, chlorella, whey, athletic blends, etc.)
Soups, stews, etc.
Coffee, tea, ginseng, chocolate (caffeine containing foods or beverages)
Alcohol, beer, wine, mixed drinks. How often, and what type ?
Clean fresh water. I drink how much each day?
"White foods" (white rice, white noodles, white breads, white sugar, white milk, white salt, etc.)
Raw foods (salads, nuts, sushi, etc.)
Seed oils such as cotton seed, soy, canola, corn, palm, etc.
Clear extra virgin coconut oil (EVCO) or extra virgin olive oil
Wild or semi-wild foods, such avocado, mango, coconut, fresh ocean fish, berries, etc.
Other not listed above. Please explain.

Please comment here

Foods and Beverages Consumed DAILY

Do You Eat in Restaurants / Cafes / Street Vendors, etc?

If possible, please tell us the names of those you most frequent, and your review of them. We publish a list of eateries suitable for our patients.

Almost never

1-3 times per week

3-6 times per week

1 time each day

2 times each day

3 times each day

Please comment here

Nutritional Supplements – Total daily / weekly / monthly

Vitamin A / total daily

Vitamin B Complex or singular B vitamins / total daily

Vitamin C tablets, pills, powders, etc. / total daily

Vitamin D / total daily

Vitamin E / total daily

Minerals, combined or singular / total daily

Green powders, spirulina, chlorella, etc. / total daily

Body building powders / drinks, etc. / when and how much

Probiotics. Please name type and how often.

Herbal supplements / teas, powders, etc.

BSI Therapure Nutraceuticals consumed presently or in the past

Injectable supplements / medicines / vitamins when & totals

Other nutritional items not listed here

None of the above

Please comment here

PART FIVE : QUESTIONS RELATED TO COVID EXPOSURES & PRESENT HEALTH STATUS

My Current Covid-Related Issues - Urgent Considerations

I currently have occasional or constant moderate to severe chest pain. Please indicate specifically where and all related factors.

I currently have heart arrhythmia, occasional or more constant

I currently experience a racing heart when standing or walking

I currently have severe shortness of breath, chronic bad cough

I currently have strange mucous coming from my nose or mouth, perhaps sticky, yellow or green color, etc. Please explain

I currently have unexplained cough, sore throat, severely blocked nose, or sinus symptoms

I currently have moderate or severe reduced exercise tolerance

I currently have blocked arteries, blocked circulation

I currently have one-sided weakness, facial droop, speech difficulty, or sudden vision loss

Please comment here

Ex. Shortness of breath : Jan 2022

Please comment here

Ex. Shortness of breath : Jan 2022

I currently have severe headache unlike my usual headache

I am currently suffering stroke or inhibited brain function due to Covid exposures

I currently experience numbness, tingling, burning pain, tremors, or localized weakness

I currently have unusual brain fog / memory loss

I currently experience dizziness when standing, lightheadedness, or near-fainting

I currently have unusual sleep problems

I currently have moderate to severe anxiety, low mood, irritability, or mood changes, probably related to Covid exposures

I currently and consistently have unusual emotional states, anger, confusion, etc.

I am currently affected by electro-magnetic waves, e.g. cellular telephones, high power electrical systems, WIFI, etc.

Please explain

I currently have calf swelling, calf pain, or sudden cramping or loss of use of body functions. Please explain

I currently have uncontrolled fever in various parts of the body, stiff neck, or severe dehydration

I currently have moderate to severe muscle pain, joint pain, or body aches, probably related to Covid

I currently have moderate to severe weakness, fainting, confusion, or difficulty staying awake

I currently have unexplained fever, chills, or night sweats

I currently have paralysis, partial or intermittent, please clarify

I currently have unexplained stomach pain, diarrhea, constipation, bloating, or nausea, perhaps related to Covid

I am currently having trouble digesting most foods

I am told I have bad breath most of the time

I currently have diseased teeth, gums, oral glands, oral ulcerations, oral pain

I have become addicted to junk foods

I am currently and / or constantly constipated

I currently have bloody or very dark stools

I currently have yellow / green / white or other color stools

I currently have lost taste or smell, or distorted smell or taste

I currently have consistent nausea, need to vomit, often vomit, often belch

I currently have bad or metallic taste in my mouth or a metallic or fowl smell in my nose

I currently have diabetes that happened after Covid exposures

I currently have skin rashes, hives, flushing, or sensitivity reactions

I currently have raised bumps or eruptions since Covid exposures

I currently have unusual fiber-like substances emerging from skin, sometimes termed Morgellon's Syndrom

I currently have moderate to severe allergies. Please explain, important
My skin is currently peeling, and may also have a fungus odor
I currently have various symptoms that come and go in waves
(If female) My menstruation has changed, has stopped from Covid exposures
(If female) My menstruation has increased, too-frequent flow
(If female) I am experiencing unusual or moderate to severe mood changes related to menstruation, since Covid exposures
(If female) I have begun menstruation again, after menopause
(If female) I am unable to conceive or get pregnant or related complications
(If female) I miscarry each time I get pregnant
(If male) I currently have erectile dysfunction and / or testicle or penile shrinkage
(If male) I am currently taking medication to stimulate erection due to Covid exposures
(If male) My sperm count is low or non-productive
(If male) I have unusual discharge from my penis, not related to STDs or similar
(If male) I have inflammation of the prostate, possibly related to Covid exposures
(If male) I am experiencing unusual or moderate to severe mood changes, possibly related to Covid exposures

Please comment here

Ex. Shortness of breath : Jan 2022

My Past or Previous Unexplained or Sudden New Illness, Long Covid, Any Time After Covid Illness or Covid Injections, Nasal Swabs, or Shedding from Others. From January 2020 Through to Present - These problems may or may not have improved over time

I had a sudden new illness after a Covid injection, nasal swab, or shedding from others. Please explain
I had symptoms that began within 24 hours after an injection, nasal swab, or shedding from others
I had symptoms that begin within 7 days after an injection, nasal swab, or shedding from others
I had symptoms that begin within 30 days after an injection, nasal swab, or shedding from others
My symptoms continued for more than 4 weeks after Covid infection or inoculations
My symptoms continued for more than 12 weeks
I have tested positive for Covid by PCR, rapid antigen, or another laboratory test
I have had Covid (unusual) symptoms without a confirmed test
I have had (unusual) symptoms that come and go in waves
I had a reaction strong enough to miss work, seek medical care, or visit emergency services after injection or nasal swab
I performed tests after the reaction, such as ECG, troponin, D-dimer, inflammatory markers, imaging, or blood tests
I have received unusual lab results after Covid or related exposures
I have developed new high blood pressure or unstable blood pressure after Covid exposures

Please comment here

Ex. Sudden new illness : Jan 2021 - Feb 2023

Please comment here

Ex. Developed low to severe arm pain : Jan 2022 - Mar 2022

I have developed new high blood pressure or unstable blood pressure after Covid exposures

I developed chest pain, shortness of breath, or palpitations after injection or nasal swab

I have checked oxygen saturation by myself (not at a medical office)

My oxygen level has repeatedly dropped below 94%

I have needed emergency care, oxygen, or hospital admission for Covid

I have had ongoing cough or breathlessness

I have had pneumonia, bronchitis, or lung inflammation after Covid exposures

I have had unexplained cough, sore throat, blocked nose, or sinus symptoms

I have had unexplained shortness of breath, chest tightness, or reduced exercise tolerance

I have experienced unusual fatigue that is different from normal tiredness

I have felt worse after physical or mental activity, even mild activity

I have needed unusually long recovery after exertion

I have experienced a racing heart when standing or walking

I have developed new heart rhythm problems

I have had sudden severe headache, vision change, weakness on one side, or speech difficulty after Covid exposures

I have had brain fog, poor concentration, or memory problems

I have had headaches that were new in type or more frequent

I had had prolonged fever, severe headache, or unusual weakness after injection or nasal swab

I have experienced anxiety, low mood, irritability, or mood changes after Covid

I fainted, felt dizzy, or developed rapid heartbeat shortly after an injection or nasal swab

I have developed new sleep problems

I developed new neurological symptoms after the injection or nasal swab

I developed low to severe arm pain, nerve pain, swelling, or reduced arm movement after injections

I have experienced numbness, tingling, burning pain, tremors, or weakness

I have had muscle pain, joint pain, or body aches since Covid

I have received a cancer diagnosis or cancer recurrence since Covid injection, swabs, shedding exposures

I have developed new autoimmune symptoms or have received an autoimmune diagnosis

I have developed new thyroid problems or similar glandular problems

I have developed shingles, recurrent infections, or unusual infections

I developed swollen lymph nodes after injection or nasal swab

I had immediate swelling, hives, wheezing, throat tightness, or allergic reactions directly after an injection of nasal swab

I have noticed unusual skin rashes, hives, flushing, or sensitivity reactions

I have experienced hair shedding after Covid, or after injection or nasal swab, etc.

I have had persistent swollen glands

Since January 2020, I have developed new allergies, food reactions, chemical sensitivity, or medication sensitivity that may be related to Covid exposures

I have had unexplained fever, chills, or night sweats

I have experienced stomach pain, diarrhea, constipation, bloating, or nausea after Covid inoculations or illness

I have or had developed new diabetes or abnormal blood sugar issues

I have had unexplained weight loss or weight gain after Covid exposures

I have lost taste or smell, or had distorted smell or taste since January 2020

(If female) My menstrual cycles changed after Covid or after injection or nasal swab

(If female) My menstruation has changed, or has unexpectedly stopped

(If female) My menstruation has changed, has stopped from Covid exposures

(If female) My menstruation has increased, too-frequent flow

(If female) I am experiencing unusual or moderate to severe mood changes related to menstruation, since Covid exposures

(If female) I have begun menstruation again, after menopause

(If female) I am unable to conceive or get pregnant or related complications

(If female) I miscarry each time I get pregnant

(If male) Since Covid, I have erectile dysfunction and / or testicle or penile shrinkage

(If male) My sperm count is low or non-productive

(If male) I have inflammation of the prostate, which happened after Covid exposures

(If male) I am experiencing unusual or moderate to severe mood changes, since Covid exposures

Please comment here

Ex. Unusual skin rashes : Jan 2022 - Dec 2024

Vaccines or Inoculations – Did you have reactions ? If so, how and where? Did you experience the covid infection afterward ? Have you received these over the years?

COVID 19 – FIRST SHOT – Please indicate BRAND NAME (Johnson & Johnson, AstraZeneca, Moderna, Pfizer, BioNtech, Sinovac, etc.) Please also indicate DATE and PLACE or CLINIC the shot was received (very important).

Did you have reactions? Please explain.

COVID 19 – SECOND SHOT – Did you have reactions ?

Please explain.

COVID 19 – FIRST BOOSTER SHOT – Did you have reactions ?

Please explain.

COVID 19 – SECOND BOOSTER SHOT – Did you have reactions ?

Please explain.

Please comment here

Ex. First shot : Jan 2020, Sinovac

COVID 19 – THIRD BOOSTER SHOT – Did you have reactions? Please explain.

COVID 19 – FOURTH BOOSTER SHOT – Did you have reactions?

Please explain.

COVID 19 – FIFTH BOOSTER SHOT – Did you have reactions? Please explain.

COVID 19 – SIXTH BOOSTER SHOT – Did you have reactions? Please explain.

How many times have you taken the PCR / Swab

Please comment here

Ex. Fourth Booster Shot : Jan 2022, Astra Zaneca

My Current Risk Factors in Relation to Covid Exposures....

I have asthma, COPD, heart disease, diabetes, kidney disease, liver disease, autoimmune disease, or cancer

I am pregnant, recently pregnant, or breastfeeding

I am taking immune-suppressing medication

I am taking blood thinners, heart medication, seizure medication, psychiatric medication, or hormone therapy

I have had previous vaccine reactions - please describe

I have had previous severe allergic reactions or anaphylaxis

I smoke, vape, or have occupational chemical exposure

I have mold exposure at home or work

I suffer from poor sleep, high stress, or major recent trauma

I have a family history of clotting disorders, autoimmune disease, sudden cardiac death, or early stroke

I have had a previous diagnosis of chronic fatigue syndrome, fibromyalgia, POTS, MCAS, Lyme disease, or similar chronic conditions

None of these

Please comment here

NON-Covid Vaccines or Inoculations BOTH BEFORE or Beginning January 2018 - Did you have reactions ? If so, how and where?

Chickenpox (Varicella)

Cholera

Current flu vaccination every flu season

Diphtheria-tetanus-pertussis (DTP) vaccine

Haemophilus influenzae type b (Hib)

Hepatitis A

Hepatitis B

HPV vaccine

Japanese Encephalitis

Malaria

Measles-mumps-rubella (MMR) vaccine

Meningococcal conjugate vaccine

Meningitis

Pneumococcal (PCV)

Polio vaccine

Rabies

Rotavirus (RV)

Td or Tdap vaccine (tetanus, diphtheria, and pertussis) booster each 10 years.

Typhoid and paratyphoid fever

Varicella (chickenpox) vaccine

Please comment here

Ex. Chickenpox : Before 2018, Hepatitis A : After 2018

Yellow Fever
Zoster vaccine
Other vaccination not listed above, please explain
Not sure
I have never taken any of these

Please comment here

Ex. Fourth Booster Shot : Jan 2022, Astra Zanecca

PART SIX : QUESTIONS RELATED TO BASIC HEALTH FACTORS ...

General Health Questions, during my life or currently, I have or have had....

Chronic or occasional pain. Please describe
Recent fever
New injuries. Please describe
Old injuries. Please describe
Cold chills or cold sweats
High blood pressure
Low blood pressure
Legs and feet (swelling, stiff joints, etc.)
Arteriosclerosis (blocked arteries)
Never or none of the above

Please comment here

Brain and Head Area

Balding, hair loss, blotchy hair, the patient's hair thinning or falling out prematurely
Pressure headaches
Throbbing headaches
Back-of-the-head headaches
Forehead headaches
Headaches around or behind eyes
Memory lapses
Dizziness or fainting
Diagnosed with a tumor or brain disease
Brain or head injuries at any time in life
Brain surgery
Nervousness, shaking, lack of motor control, etc.
Paralysis anywhere in the body
Lack of feeling anywhere in the body
Over-sensitivity anywhere in the body
Stroke
Scalp problems, dandruff, itching, flaking, etc.
Tumors, growths, moles, warts, etc. on the scalp or head
Other head surgeries, such as on the ear, nose, neck etc.
Something not listed above
None of the above

Please comment here

Oral and Dental during my life....

I have very healthy teeth and gums
I have missing teeth, how many
I have chipped or partial teeth
I have diseased or rotting teeth
I have bleeding gums
I have receding gums

Please comment here

I have false teeth or dentures
All or most original teeth been removed
I have amalgam fillings, how many
I have ceramic fillings, how many
I have dental caps or crowns on original teeth
I have new style, more recent root canals
I have old style root canals
I wear or have worn braces
I have dentures or bridges
I have ulcers or growths in my mouth or my tongue
I have or have had oral herpes
I have lost my sense of taste or smell
I use commercial mouth wash
I am told I have bad breath most of the time
I have excessive amounts of mucous or saliva

Please comment here

Thyroid Disorders / Swelling, during my life, I have or have had....

Taking thyroid medication?
Undergone thyroid surgery or removal?
Thyroid area inflamed or in pain?
Exposed to nuclear radiation that may have affected the thyroid?
Never or not sure

Please comment here

Sinus, Ears, Throat, I have or have had...

Recent or previous ear and/or sinus infections
Any swelling or pain in the throat area
Undergone surgeries in the throat or on the neck
Recent or previous swollen or painful lymph glands in the neck or throat area
Strained or dry voice
Lumps or hard nodules anywhere in the mouth, sinus, gums
Difficulties swallowing
Sticky mucous in the throat area
Something not listed above
Never or note sure on all the above

Please comment here

Sinus, Ears, Throat, I have or have had...

Recent or previous ear and/or sinus infections
Any swelling or pain in the throat area
Undergone surgeries in the throat or on the neck
Recent or previous swollen or painful lymph glands in the neck or throat area
Strained or dry voice
Lumps or hard nodules anywhere in the mouth, sinus, gums
Difficulties swallowing
Sticky mucous in the throat area
Something not listed above
Never or note sure on all the above

Please comment here

Eyes, during my life, I have or have had...

- Objects floating in vision
- Tunnel vision
- Poor night vision
- Wear corrective lenses
- Eye surgery (alignment, Lasix, repair, etc.)
- Full or partial blindness
- Something not listed above
- None of the above

Please comment here

Digestive System, during my life, I have or have had...

- Difficulty when swallowing
- Specific digestive issues of the liver, gallbladder, pancreas, stomach, intestines, etc.
- Diabetes / hypoglycemia / sugar cravings
- Sometimes or often constipated
- Bloating, indigestion, vomiting, excessive gas, etc.
- Occasional or frequent diarrhea
- Feces are strange color, grey, yellow, green, red, black
- Rectal bleeding, or blood in stool
- Hemorrhoids (piles)
- Anal itching or irritation
- Cramping, abdominal pain
- Any other digestive condition not on the above list
- Never or none of the above

Please comment here

Skin and Body Surfaces

- Excessive sweating or body odors
- Dry or scaly skin
- Growths, skin infections, skin irregularities of any kind on the body. Where, please describe
- Excessive bruising, discoloration or spots
- Varicose veins / Thrombophlebitis
- Cosmetic skin peels / Glycolic Acid, etc.
- Have you ever injected Botox or similar
- Fingernail or toenail changes. Please describe
- Skin surgeries / transplants of any kind. Result
- Treated for skin cancer or other growth. Where on the body, and when
- Problems not listed above
- Never or none of these

Please comment here

Respiratory System, during my life, I have or have had...

- Asthma / lung disorders
- Shortness of breath
- Chronic cough and/or chest pain
- Frequent infections
- Sinus and/or ear infections. They are treated how
- Other problems not on this list
- Never or none of the above

Please comment here

Smoking or Vaping, during my life, I use or have used...

Tobacco cigarettes, what brand(s), how often, from when to when please
Vaping. What brand(s), how often, from when to when please
Cigars, pipes, chewing tobacco, etc.
Substances other than tobacco
Never or none of the above

Please comment here

Kidneys, Adrenal Glands, Bladder, Urinary Tract. During my life, I have or have had...

Urinary tract surgery. Cause and results
Growths or eruptions on or around genitalia
Swollen lymph or lumps in around the anus, perineum, genitals, and surrounding areas
Pain or discomfort during sex
Take diuretics to facilitate urination
Urinary tract infections. Recent or frequent
Burning or difficult urination
Awakened at night to urinate. How many times
None of these or other response

Please comment here

Heart and Circulatory System. During my life, I have or have had...

Arrhythmia (irregular heartbeat)
Tachycardia (abnormally fast heart rate)
Bradycardia (abnormally slow heart rate)
Ever suffered a heart attack
Chest pains in or around the heart
Heart or related surgeries or therapies
Blood disorders
Other answer not listed above
Never, none of these

Please comment here

Male Considerations

Prostate issues – surgery, pain, etc.
Erectile problems
Any strange discharge or irritation of the penis
Testicle problems – swelling, discoloration, surgery, etc.
Sexually transmitted diseases (STDs). Now or in the past that may have affected your concerns here
Taking hormones of any kind that affect reproduction
Other condition not on this list. Please describe here
Never or none of these

Please comment here

Female Considerations

Surgery of the reproductive system. Please answer when, reason, and result
Pregnant now
Using birth control of any kind. What type, for how long
Taking hormones of any kind that affect reproduction
Currently menstruate on a consistent cycle
Are menses very heavy or very light, of strange duration.
Please comment.

Please comment here

Menopause. How long. Difficulties.
Sexually transmitted diseases (STDs). Now or in the past
Vaginitis, pain, or or vaginal discharge
Endometriosis
Breast issues (swollen lymph, pain, etc.)
Other condition not listed here
Never or none of these

Please comment here

Projected beginning of cycle

Projected end of cycle

Female Considerations

Purpose of Testing: (when performing full testing, not just specific hormones) Please be sure to schedule hormone testing in sync with menstruation. Please choose your concerns below

General hormonal function: Testing can be taken any time outside of menstruation
PCOS: Testing anytime outside of menstruation
Fertility / Ovarian function: Testing on day 3 (but cannot do urine testing this day)
Menopause / Peri-menopause : Testing on day 3 (but cannot do urine testing this day)
Heavy emotions: Testing around days 19-22
Light or Heavy menses: Testing around days 19-22
Specific concerns about Estrogen or Progesterone: Testing days 19-22
Missing period: Testing any time

Please comment here

PART SEVEN : PATIENT DISEASE AND CAUSES...

Allergies. In the past few years, I have or have had allergies to...

Animals
Certain drugs
Diary products
Dust
Mold or mildew
Nuts or seeds
Other allergens not listed
Never or not sure

Please comment here

Autoimmune Disorders. During My Life or Recently, I Have or Have Had...

Alopecia areata. Sudden hair loss that starts with one or more circular bald patches that may overlap.
Ankylosing spondylitis. An inflammatory arthritis affecting the spine and large joints.
Celiac disease. An immune reaction to eating gluten, a protein found in wheat, barley and rye.
Lupus. An inflammatory disease caused when the immune system attacks its own tissues.
Multiple sclerosis. A disease in which the immune system eats away at the protective covering of nerves.
Polymyalgia rheumatica. An inflammatory disorder causing muscle pain and stiffness around the shoulders and hips.

Please comment here

Rheumatoid arthritis. A chronic inflammatory disorder affecting many joints, including those in the hands and feet.
Sjögren's syndrome. An immune system disorder characterised by dry eyes and dry mouth.
Temporal arteritis. An inflammation of blood vessels, called arteries, in and around the scalp.
Type 1 diabetes. A chronic condition in which the pancreas produces little or no insulin.
Vasculitis. An inflammation of the blood vessels that causes changes in the blood vessel walls.
Other conditions not listed above.
Never or not sure.

Please comment here

Cancers. During My life, I Have or Have Had...

I now have cancer, or previously had cancer. Please comment
Stage and type of cancer (if any, in detail please)
Results of any previous medical tests.
Intravenous chemotherapy
Oral chemotherapy
Hormone therapy
Radiation therapy
I have received holistic or natural therapy for cancers and related diseases
Other not listed here. Please explain.
My condition has improved or healed, please explain.
My condition has worsened, please explain.
Not sure
None of the above

Please comment here

Hepatitis or Liver Disease

Yellowing of the eyes or skin?
Hepatitis A (HAV) (Hepatitis A is spread primarily through food or water contaminated by stool from an infected person. Hepatitis A is a food-borne or waterborne illnesses.)
Hepatitis B (HBV) (The hepatitis B virus is spread through blood, semen, or other body fluids.)
Hepatitis C (HCV) (The hepatitis C virus is spread through contact with an infected person's blood — because of genital sores or cuts or menstruation. Also through injection drug use, unsafe injection practices, unsafe health care, and the transfusion of unscreened blood and blood products.)
Hepatitis D. (HDV) (Hepatitis D infection only occurs in the presence of hepatitis B virus. HDV-HBV co-infection is considered the most severe form of chronic viral hepatitis.)
Hepatitis E (HEV) (The hepatitis E virus is transmitted mainly through contaminated drinking water. It is usually a self-limiting infection and resolves within 4 to 6 weeks.)
NON-viral Hepatitis. Please describe
Never or none of the above

Please comment here

Herpes. In my life, I have or have had...

Please comment here

Herpes Simplex 1 (HSV-1) (oral cold sores in or around the mouth or lips. Associated with bipolar disorder, Alzheimer's disease and more)

Herpes Simplex 2 (HSV-2) (genital / anal area breakouts. Associated with (Mollaret's meningitis)

Herpes 3 (HHV-3 or VZV) (chickenpox, shingles, human herpes varicella-zoster)

Herpes 4 (Epstein Barr HHV 4) (associated with mononucleosis, lymphomas, lupus, arthritis, MS, Chronic Fatigue, etc.)

Herpes 5 (cytomegalovirus HHV 5 or CMV) (associated with Infectious mononucleosis ('kissing disease'), retinitis)

Herpes 6 (HHV-6) (associated with Chronic Fatigue Syndrome, cognitive dysfunction, autonomic dysfunction, roseolovirus, lymphotropic virus – infects approximately 70% of humans. Symptoms consistent with hepatitis and encephalitis)

Herpes 7 (HHV-7) (associated with pityriasis rosea. Also associated with drug-induced hypersensitivity syndrome, encephalopathy, hemiconvulsion-hemiplegia-epilepsy syndrome, hepatitis infection, postinfectious myeloradiculoneuropathy, pityriasis rosea, and the reactivation of HHV-4, leading to "mononucleosis-like illness")

Herpes 8 (HHV-8) (Associated with neoplasms. Diseases caused by HHV-8 infection include Kaposi Sarcoma, Multicentric Castleman Disease (MCD), Primary Effusion Lymphoma (PEL), which occur primarily in patients with HIV infection)

ParvoVirus (B-19) (associated with slapped cheek syndrome, sero negative arthritis, aplastic anemia, sickle cell disease, encephalitis, meningitis, stroke, peripheral neuropathy, and more)

Not sure or other condition not listed above. Please explain
Never or none of these

Toxic Exposures, during my life, and / or more recently

Please comment here

Exposed to chemicals or toxins related to machine work, solvents, fuels, industrial cleaners, etc?

Insect or weed killers in the house or around where you are (how often, what brand?)

Insect repellants sprayed or rubbed onto the body (how often, what brand?)

Briefly describe any toxic chemical exposures at any time during the Patient's life

Party favors in the past three years

Other exposures not listed above. Please explain

Never or none of the above

Radioactivity Exposures, during my life, and / or more recently

Radioactive exposures from frequent flying (how many flights per year)

Radioactive exposures from CT scans, MRI, X-rays. How many times. Contrast injected into the body during the procedure

Use of cell phone next to the head (how many hours per day on average)

Live within 100 meters of a cellular or radio broadcast tower. Please explain.

I have lived or worked near a nuclear power plant or nuclear facility

I have lived near or visited Chernobyl, Fukushima, Hanford or other contaminated area

I have suffered from unexplained sudden hair loss or skin mottling, etc.

Any other source of radioactivity not listed above. Please explain

Not sure

Never or none of the above

Please comment here

PART EIGHT : MEDICATIONS PAST AND PRESENT ...

Common Medications I Have Taken During the Past 2 Years or Less

Aspirin / Other pain killers

Ibuprofen (Advil / Motrin)

Panadol / Paracetamol / Tylenol / Benadryl / Acetaminophen

Sudafed / Claritin / anti-histamine

Diuretics (ease urination)

Coumadin/ Heparin/ blood thinners (stroke prevention)

Statins for cholesterol, (Lipitor, Crestor, Zocor)

Prozac or similar

Anti-fungal (on skin or orally)

Estrogen / HGH / other hormones

Other not listed above. Please describe. Thanks.

Not sure

None of these

Please comment here

All CURRENT medications, supplements, herbal medications, etc. you are taking

Antibiotics in the Past 5 Years

Amoxicillin. A penicillin antibiotic prescribed for tonsillitis, bronchitis, pneumonia, gonorrhea, and infections of the ear, nose, throat, skin, or urinary tract, and more.

Amoxicillin / Clavulanate. A combination penicillin antibiotic that fights bacteria in the body.

Azithromycin. Given for respiratory, skin, and ear infections, and sexually transmitted diseases.

Cephalexin. Prescribed for upper respiratory infections, ear infections, skin infections, and urinary tract infections.

Ciprofloxacin (fluoroquinolone). Prescribed for anthrax, plague, stomach disorders and more.

Clindamycin. A wide-spectrum antibiotic that fights bacteria in the body.

Doxycycline. For urinary tract infections, intestinal infections, eye infections, gonorrhea, chlamydia, periodontitis (gum disease), and others.

Levofloxacin (fluoroquinolone). For skin, sinuses, kidneys, bladder, prostate, bronchitis, pneumonia, anthrax.

Metronidazole (Clindamycin hydrochloride). A strong wide spectrum antibiotic that fights bacteria in the body.

Sulfamethoxazole / Trimethoprim. Used to treat or prevent wide spectrum of bacterial infections.

An antibiotic not on this list.

Exposure from foods such as chicken, eggs, fish, meat, etc.

Never have taken antibiotics.

Please comment here

PART NINE : THERAPIES PAST AND PRESENT ...

Present Happiness and Well Being

I am generally happy and content...

My strengths are...

My weaknesses are...

I suffer / have suffered from depression...

I suffer / have suffered from anxiety...

I have taken / take medications for depression or anxiety...

I am easily angered, triggered by...

I practice / have practiced a form of mind centering, such as meditation or quiet time...

Other answer not listed above

Please comment here

Therapies Received in the Past 2 Years or Now Receiving

Acupuncture

Aromatherapy

Chelation therapy

Colonic therapy

Detoxing

Cannabis

Chemotherapy

Herbal medicine

Homeopathy

Please comment here

Naturopathy
Oxygen therapy
Prolo Therapy
Radiation Therapy
Reiki
Vitamin C infusions (dosage, how often, any side effects ?)
Other therapy not on this list
Never or none of the above

Surgeries and Operations, in My Lifetime and / or Recently

Appendix removed
Tonsils removed
Digestive surgeries
Elective surgeries. Please explain
Emergency surgeries
Eye operations
Heart
Skin operations, including growths or cancers, etc.
Other surgeries not listed above, please explain here
None of the above

Please comment here

Anti-Fungal Medicines I Have Taken During My Life, and Recently...

Oral anti-fungal medicines
Topical anti-fungals
Not sure or other medicine, please explain
Never or none of the above

Please comment here

Parasites and Related Causes and Effects - Diagnosis and Treatments During My Life or Recently...

Treated for digestive parasites. If so when and how. Did the treatment work
Treated for skin or hair parasites
Frequent bloating or gas
Anal bleeding or itching
Strings or mucous in the stools
I live with dogs or cats
I swim in tropical rivers or lakes
I eat raw foods
Other parasite problems not listed here. Please explain
Never or none of these. Please explain

Please comment here

Anything Else of Relevance

Note :
Please fill this offline form, then Save it
Send this form via email to : **survey@bsi.international**
- or -
Print and bring with you to your first meeting.
(Please note this will add 30 minutes to your first visit).