



NATURAL

Health Services

Hi

It was a pleasure to meet you. I enjoyed having you in the workshop.

Your appointment is on: _____

Please complete the questionnaires (enclosed) and bring them to the health evaluation appointment. They are double-sided, so please complete, both sides. The questions along with your examination will help us get to the cause of your problems. The more information you provide, the better we can help you by addressing the cause and finding the solution.

Please fast for 2 hours before your appointment, nothing in your mouth at all, no gum, candy, toothpaste, tobacco or cigarettes, soda, liquids of any kind, etc.

You can have only, plain, unflavored water up to an hour prior to your appointment.

The examination and evaluation will give us insight into your body function, the cause of symptoms and possible future problems.

I look forward to seeing you for your health care evaluation and assisting you with your health goals.

Cancellation policy: 24-hour notice is required for changing appointments.

Otherwise you will incur a missed appointment charge or forfeit the Evaluation and Report of Findings appointment. Thank you.

Irene Beikoussis, MS, CHHP, NC

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Client Case Record

Name: _____ Date: _____ Client ID#: _____
Home phone: _____ Work & Cell phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Age: _____ Birth date: _____ Weight: _____ Height: _____ Sex: _____
Occupation: _____ S.S.#: _____
Who referred you? _____

Please list the five main important complaints in order of importance:

1. _____ When did it start? _____
2. _____ When did it start? _____
3. _____ When did it start? _____
4. _____ When did it start? _____
5. _____ When did it start? _____

Current Medications taking:

History of illness and treatments:

Allergies / Sensitivities:

Current **Wellness** Practitioner

Is Your Wellness Plan Working?

Are you happy with your Wellness Plan?

Height: _____

Weight: _____

Blood Pressure: _____

Practitioners Notes:

HRT, Birth Control Pills - time: _____
History of refined carbohydrates – time: _____
History of sugar – time: _____
History of caffeine – time: _____
History of low calorie diet – time: _____
History of medication, drugs – time: _____
History of steroids – time: _____
History of non-organic – time: _____
History of x-rays or radiation: _____
History of lack of sleep – time: _____
History of alcohol – time: _____
History of smoking – time: _____
History of chemical exposure – time: _____
History of parent genetic weakness: _____
History of grandparent genetic weakness: _____
History of stress events – time: _____
Other: _____



The following information will help to better serve you. Please fill in all portions of the form. If you need any help, we will be happy to assist you.

Name _____

Date _____

Your obstacles to Body/Mind Health

List the most aggravating symptoms/conditions from which you suffer, starting with the most aggravating first. Think back to when you felt your best and list all symptoms that you have experienced or still experience. Sometimes you get used to them, so please think when you didn't have them. **You can use the reverse – if necessary.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

Your Optimal Health Goals

Briefly describe the health improvements that you would like to achieve, in the following areas:

- 1.
- 2.
- 3.
- 4.
- 5.

Your Personal Style of Growth and Change

Which best describes how you perceive your ability to make dietary/lifestyle changes once you are convinced of the need to follow a new program? *(Check the boxes of all that apply)*

- I am very motivated and always follow through with what I take on
- I am very motivated and enthusiastic initially, but at times do not follow through
- I often initially take on more than I can really handle
- I am cautious at first, yet I follow through with I decide to do
- I need to take small steps, and need to have regular support to make major changes
- I am motivated and disciplined, but often do not ask for the support that I need
- I need a complete change of environment and constant support to make major changes

Confidential Patient Case History, Part 1

Name _____ Date _____

What is your major health concern? _____

Other concerns? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

How did it originally occur? _____

Is this condition getting progressively worse? Yes ___ No ___ Constant ___ Comes and Goes ___

If yes, when and how? _____

How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Other ___

Are there any other conditions or symptoms you have that may be related to your major symptom?

Yes ___ No ___ If yes, describe. _____

Are there other unrelated health problems? _____

Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___ Burning ___

Radiating to Other Areas? Where? _____

Is there anything you can do to relieve this problem? Yes ___ No ___ If yes, describe: _____

If no, what have you tried that has not helped? _____

What makes the problem worse? Standing ___ Sitting ___ Lying ___ Bending ___ Lifting ___

Twisting ___ Other _____

Is this condition interfering with your: Work ___ Sleep ___ Daily Routine ___ Other _____

How long has it been since you have felt really well? _____

List previous diagnoses and treatments you have received for present condition. _____

What do you believe is wrong with you? _____

List surgical operations and years: _____

Drugs you now take: Anti-depressants ___ Pain Killers ___ Muscle Relaxers ___ Diabetic ___

High Blood Pressure ___ Thyroid ___ Birth Control or Hormones ___ Other _____

Do you wear heel or arch support? Yes ___ No ___ How long? _____

Do you use any magnetic therapy products? Yes ___ No ___ If yes, please list _____

Have you had any broken bones? Yes ___ No ___ If yes, list and give dates: _____

Have you had any major accidents? Past year ___ Past 5 years ___ Over 5 years ___ Never ___

Describe _____

To your knowledge, have you had any diseases, major illnesses, injuries or other important health history not indicated on this form either in the past or present? Yes ___ No ___

If yes, please explain: _____

Confidential Patient Case History, Part 2

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your evaluation, overall treatment plan, and the possibility of being accepted for care. Please place the appropriate letter in the spaces provided for any symptoms you now have or have had within the last year.

O = Occasional

F = Frequent

C = Constant

General

- Allergies
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety
- Depression
- Neuralgia
- Numbness
- Sweats
- Tremors

Muscle and Joint

- Arthritis
- Jaw Pain/Clicking
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Neck Pain/Stiffness
- Pain B/W Shoulders
- Painful Tail Bone
- Poor Posture
- Sciatica
- Swollen Joints
- Spinal Curvature

Pain or Numbness in:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Ankles
- Feet

Gastrointestinal

- Belching/Gas
- Colitis
- Colon Trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Distension of Abdomen
- Excessive Hunger
- Gallbladder Trouble
- Hemorrhoids
- Intestinal Worms
- Liver Trouble
- Jaundice
- Nausea
- Stomach Pain
- Poor Appetite
- Vomiting
- Heartburn

Eyes, Ears, Nose & Throat

- Asthma
- Colds
- Deafness
- Dental Decay
- Earache
- Ear Discharge
- Ear Noises
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Far Sightedness
- Near Sightedness
- Nasal Obstruction
- Gum Trouble
- Hay Fever
- Hoarseness
- Nose Bleeds
- Sinus Infection
- Sore Throat
- Tonsillitis

Cardiovascular

- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Rapid Heart Beat
- Slow Heart Beat
- Ankle Swelling

Respiratory

- Chest Pain
- Constant Cough
- Spitting up Blood
- Difficult Breathing
- Spitting up Phlegm
- Wheezing

Skin

- Bruise Easily
- Boils
- Varicose Veins
- Dryness
- Hives or Allergy
- Itching
- Rash (Skin Eruptions)

Genito-Urinary

- Pus in Urine
- Bed-Wetting
- Blood in Urine
- Frequent Urination
- Bladder Control Trouble
- Kidney Infection/Stones
- Painful Urination
- Prostate Trouble

For Women Only

- Pregnant? Yes ___ No ___ Maybe ___
- Breast Fullness/Tenderness
- Vaginal Discharge
- Excessive Menstrual Flow
- Painful Menstruation
- Irregular Cycle
- Menopausal Symptoms

Check any of the following conditions you have had:

- | | | | |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mumps | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Malaria | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> HIV Virus | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Chorea | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Migraines | <input type="checkbox"/> Crohn's Disease |

<u>Habits:</u>	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Negative Thinking	_____	_____	_____	_____
Fun	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____

Date of Last:

Physical Exam _____ Blood Test _____ Urine Test _____
 Spinal X-ray _____ Chest X-ray _____ Other _____

Please check the symptoms that apply:

Thyroid

- | | | |
|---|--|--|
| <input type="checkbox"/> Stubborn Weight | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Intolerance to cold |
| <input type="checkbox"/> Cold hands/feet or low body temperature | <input type="checkbox"/> Dry or itchy skin | <input type="checkbox"/> Sluggish elimination/constipation |
| <input type="checkbox"/> Mental sluggishness or lethargy | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Flabby skin under arms or neck | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Lack of interest in life | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Ridged nails (vertical) or brittle nails | <input type="checkbox"/> Pain in the wrist (carpal tunnel) | <input type="checkbox"/> Cravings for sweets |
| <input type="checkbox"/> Insomnia | | |

Adrenal/Heart/Blood Pressure/Cholesterol

- | | | |
|--|--|---|
| <input type="checkbox"/> Out of breath walking up stairs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive facial hair – female |
| <input type="checkbox"/> Perspiring after getting out of shower | <input type="checkbox"/> Fatigue during the day | <input type="checkbox"/> Difficulty getting out of bed in morning |
| <input type="checkbox"/> Waking up in the middle of the night | <input type="checkbox"/> Difficulty falling to sleep | <input type="checkbox"/> Afternoon headaches |
| <input type="checkbox"/> Arthritis or stiff and painful joints | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Twitch under the eyelid | <input type="checkbox"/> Heel spurs | <input type="checkbox"/> Low back weakness or pain |
| <input type="checkbox"/> Itchiness or hives | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Dehydrated despite amount of fluid consumed | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Craving salt (chips, pretzels) | <input type="checkbox"/> Enlarged abdomen |
| <input type="checkbox"/> Enlarged bump in upper back/lower neck | <input type="checkbox"/> Hands & feet go to sleep easily | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Aware of breathing heavily | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Muscle cramps, worse during exercise |
| <input type="checkbox"/> Dull pain in chest or radiating in left arm | <input type="checkbox"/> Ringing in ears | |

Digestion/Arthritis

- | | | |
|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty sleeping through the night | <input type="checkbox"/> Early morning insomnia |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stomach bloats when eating wheat or sugar | <input type="checkbox"/> Blood sugar problem | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Burning feet | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Itchy skin and feet |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bowel movement light colored | <input type="checkbox"/> Pain between shoulder blades |
| <input type="checkbox"/> Sneezing attacks | <input type="checkbox"/> Nightmare type dreams | <input type="checkbox"/> Eating protein causes gas |
| <input type="checkbox"/> Coated tongue (white film) | <input type="checkbox"/> Indigestion, acid reflux | <input type="checkbox"/> Irritable bowel problems |
| <input type="checkbox"/> Difficulty getting out of bed in the morning | <input type="checkbox"/> History of birth control pills | <input type="checkbox"/> History of antibiotics |
| <input type="checkbox"/> History of eating refined carbohydrates/sugar | <input type="checkbox"/> Toenail fungus | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> Redness in eyes | <input type="checkbox"/> Fibromyalgia (tender spots in muscles) |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Right shoulder pain or tightness |
| <input type="checkbox"/> Abdominal bloats after eating | <input type="checkbox"/> Full sensation under rib cage | <input type="checkbox"/> Belching/burping after eating |
| <input type="checkbox"/> Yellowish color in whites of eyes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Itchy private parts | <input type="checkbox"/> Yeast or candida | |

Menopause (female only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Leaking bladder | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Bone loss/osteoporosis |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> History of birth control pills | |

Menstrual (female only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Infertile (difficulty in getting pregnant) | <input type="checkbox"/> PMS | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Depression during menstruation | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Weight gain during menstruation |
| <input type="checkbox"/> Bloating and cramping during menstruation | <input type="checkbox"/> Weight gain during ovulation | <input type="checkbox"/> Difficulty losing weight after pregnancy |
| <input type="checkbox"/> Heavy bleeding during menstruation | <input type="checkbox"/> Pain in low back/pelvic area | <input type="checkbox"/> Pain in the front hip area |
| <input type="checkbox"/> Acne during menstruation | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Enlarged swollen breasts during menstruation | <input type="checkbox"/> Bladder infections (recurrent) | |

Blood Sugar

- | | | |
|--|---|---|
| <input type="checkbox"/> History of diabetes in family | <input type="checkbox"/> Tired at 3:00 p.m. (afternoon) | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Cravings for sweets, refined carbohydrates | <input type="checkbox"/> Awake after a few hours of sleep | <input type="checkbox"/> Weight gain during menstruation |
| <input type="checkbox"/> Wake early a.m. and can't get back to sleep | <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty losing weight after pregnancy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Pain in the front hip area |
| <input type="checkbox"/> History of eating lots of sugars, refined carbohydrates | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Numbness or tingling in finger tips or toes | <input type="checkbox"/> Lightheaded if hungry | <input type="checkbox"/> Eating improves fatigue |
| <input type="checkbox"/> Afternoon headaches | <input type="checkbox"/> Fatigue 1 to 2 hours after eating sugar or refined carbohydrates | |

Prostate (male only)

- | | | |
|--|--|--|
| <input type="checkbox"/> Urination difficulty or dribbling | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Pain on inside of heels or legs |
| <input type="checkbox"/> Lack of vigor or vitality | <input type="checkbox"/> Legs nervous at night | <input type="checkbox"/> Diminished sex drive |
| <input type="checkbox"/> Impotency | <input type="checkbox"/> Infertile | |

Stubborn Weight

- | | | |
|---|---|---|
| <input type="checkbox"/> Cravings for junk food | <input type="checkbox"/> Drinks wine in evenings | <input type="checkbox"/> Craves refined carbohydrates |
| <input type="checkbox"/> Frustrating stubborn weight | <input type="checkbox"/> History of low-calorie diets | <input type="checkbox"/> History of up and down weight |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> History of birth control pills | <input type="checkbox"/> High protein diets don't work |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> Poor will power | <input type="checkbox"/> Can't lose weight despite exercise |
| <input type="checkbox"/> History of blood sugar problems | <input type="checkbox"/> History of menstrual problems | |

CHEMICAL BALANCE QUESTIONNAIRE

Speed of healing is greatly affected by the **chemical balance** within the body. This chemical balance is determined, in large part, by **what you eat and drink**. Please indicate the amounts and frequencies of which you partake in the following: **BE HONEST!!**

	Per Day	Per Week
1. Coffee (caffeinated/decaffeinated)	_____ cups	_____ cups
2. Tea (herbal/regular)	_____ cups	_____ cups
3. Soda (regular/caffeine-free)	_____ oz.	_____ oz.
Diet Soda	_____ oz.	_____ oz.
4. Sugar, sweets, desserts, candy	_____ times	_____ times
5. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
6. Red meat (beef, pork, bacon, ham, etc.)	_____ times	_____ times
7. Chicken/Fish	_____ times	_____ times
8. Milk	_____ glasses	_____ glasses
Other Dairy (cheese, ice cream, etc.)	_____ cups/ounces	_____ cups/ounces
9. Water (city, well, distilled, RO, etc.)	_____ glasses	_____ glasses
10. Fresh fruit	_____ pieces	_____ pieces
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Pasta, breads (made with white flour)	_____ servings	_____ servings
13. Whole grain foods	_____ servings	_____ servings
14. Artificially sweetened products (Sweet-N-Low, Aspartame, Equal, etc.)	_____ servings	_____ servings
15. Fast Food (McDonald's, Hardee's, etc.)	_____ times	_____ times
16. Do you add salt to food at mealtime?	_____ Yes _____ No	_____ Occasionally

Diet:

Give some examples of types your eating patterns:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Liquids: _____

List all supplementation you are currently taking (vitamins, minerals, homeopathics, etc.):

Major life changes (divorce, losses, trauma, etc.):

Treatment Acknowledgement

Why **B.E.S.T.**, **B.R.T.**, and **other non-invasive techniques**? People go to **Holistic Practitioners** for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, relieved and corrected (Corrective Care). Still others want whatever is malfunctioning within them brought to the highest state of health possible (Comprehensive Care). Irene Beikoussis, M.Sc., CHHP, NC will weigh your needs and desires when recommending your treatment program. Please check the type of care desired:

Relief Care __ **Corrective Care** __ **Comprehensive Care** __ **Doctor to Select Appropriate Care**__

I hereby authorize **Irene Beikoussis, M.Sc., CHHP, NC** to find the cause of my condition, as she may deem appropriate through the use of **B.E.S.T.** treatments, **B.R.T.** treatments, other therapy, and such additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and fully understand this Authorization for treatment. Irene Beikoussis, MSc, CHHP, NC will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

Patient's Name (Please Print) _____

Patient's Signature _____ **Date** _____

Signature of Guardian Authorizing Care _____ **Date** _____

I hereby acknowledge that **Irene Beikoussis, M.Sc., CHHP, NC** is evaluating me to determine whether I have nutritional deficiencies. If so, at my request, he will suggest a nutritional program as an adjunctive procedure provided solely to upgrade my diet in order to supply proper nutrition for support of the physiological and biochemical processes of the human body. This treatment is not intended to replace any existing or future care by a medical doctor for any specific condition. I understand I am solely responsible for discussing with my medical doctor any such medical conditions for purpose of evaluation, diagnosis, or treatment.

Patient's Signature _____ **Date** _____

Signature of Guardian Authorizing Care _____ **Date** _____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize **Irene Beikoussis, M.Sc., CHHP, NC** and whomever he may designate as assistants to administer treatment, as they so deem necessary, to my son/daughter.

Child's Name _____

Signature of Guardian Authorizing Care _____ **Date** _____