NATURAL HEALTH CARE CENTER
Promoting Total Health Awareness

Cory M. Blust, MT
672 Miami St., Suite B
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INFORMED CONSENT

Signing this form indicates that you are voluntarily and knowingly undergoing a procedure referred to by FDA as Electro Dermal Screening. It is a form of modern bio-energetic science. The technique was discovered by Dr. Voll, M.D. of Germany around 1926.

The procedure is totally non-invasive (the skin is not punctured). This procedure includes the application of an electronic probe of five volts to measure skin resistance at selected acupuncture sites located on the hands and feet. It will then be determined as to which natural substances will be needed to re-establish proper balance to the body's chemistry.

Because the procedure involves only the measurement of changes in the meridian flow with a sensitive meter, it is completely safe. The only sensation that is usually felt is just the pressure of the electronic probe as it is pushed against the skin. The use of the computer makes the procedure extremely fast. Please note that the equipment utilized is non-diagnostic in nature.

At no time will there be any implied and/or stated indication for any client to discontinue taking any medication as prescribed by his/her physician. At no time will there be any implied and/or stated indication to any client to discontinue care under the direction of any other physician. This procedure is approved by the FDA for investigative use only at this time and is non intended, implied or stated to take the place of any conventional medical test and/or diagnostic procedure.

At no time can this office guarantee implied and/or stated resolvement, but it has been found that complete client compliance to the natural health care recommendation usually results in greater and more consistent changes towards better health. If you, the client, wish to decline participation in this program, you may do so at any time. This office reserves the right to dismiss any client at any time due to poor compliance to the program.

I have fully read and understand the above information, the elements of informed consent, my responsibilities and rights, and hereby consent to the participation in the Electro Dermal Screening procedure.

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

WITNESS _____ DATE _____

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Homeopathy/Meridian Stress Assessment/Electro Dermal Screening

MEDICAL CLIENT/FAMILY HISTORY

GENERAL INFORMATION

Name _____

Address _____ _____ _____ _____
No./St./Rd. City State Zip

Phone: Home _____ Cell Phone _____ Work _____

E-Mail Address _____

Sex: F ☐ M ☐ Age _____ Date of Birth _____ Marital Status: S ☐ M ☐ D ☐ W ☐

Client employed by _____

Referred By _____

Current Treating Physician _____

Current Rx (Prescription) Medications _____

_____

_____

Current Over-the-Counter Medications _____

_____

_____

Current Health Care Professional(s) You Are Working With (Therapists, Healers, Helpers, Etc.) _____

_____

_____

Current Non-Rx Supplements (Vitamins, Minerals, Herbal, Homeopathic, Etc.) _____

_____

_____

Illnesses, Operations, Accidents, Injuries, Diseases _____

_____

_____

Illnesses, Operations, Accidents, Injuries, Diseases (continued)

_____

_____

_____

REVIEW OF SYMPTOMS

Chief Complaints/Symptoms in order of severity:

1) _____

2) _____

3) _____

4) _____

5) _____

CLIENT'S SOCIAL HISTORY

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously, But Quit ☐ Current Packs/Day

Use of Drugs ☐ Never Type/Frequency _____

Excessive Exposure at Home or Work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Air-Borne Particles ☐ Noise

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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Homeopathy/Meridian Stress Assessment/Electro Dermal Screening

Client _____ Date _____

Instructions: Write the number that applies to you. **If a symptom does not apply, leave it blank.**
Write either: **(1)** for **Mild** symptoms (occurs rarely), **(2)** for **Moderate** symptoms (occurs several times a month), or **(3)** for **Severe** symptoms (occurs almost constantly).

Group One

1 - ____ Acid foods upset
2 - ____ Get chilled, often
3 - ____ "Lump" in throat
4 - ____ Dry mouth-eyes-nose
5 - ____ Pulse speeds after meal
6 - ____ Keyed up - fail to calm
7 - ____ Cuts heal slowly
8 - ____ Gag Easily
9 - ____ Unable to relax, startles easily
10 - ____ Extremities cold, clammy
11 - ____ Strong light irritates
12 - ____ Urine amount reduced
13 - ____ Heart pounds after retiring
14 - ____ "Nervous" stomach
15 - ____ Appetite reduced
16 - ____ Cold sweats often
17 - ____ Fever easily raised
18 - ____ Neuralgia-like pains
19 - ____ Staring, blinks little
20 - ____ Sour stomach frequent

Group Two

21 - ____ Joint stiffness after arising
22 - ____ Muscle-leg-toe cramps at night
23 - ____ "Butterfly" stomach, cramps
24 - ____ Eyes or nose watery
25 - ____ Eyes blink often
26 - ____ Eyelids swollen, puffy
27 - ____ Indigestion soon after meals
28 - ____ Always seem hungry; Feels "lightheaded" often
29 - ____ Digestion rapid
30 - ____ Vomiting frequent
31 - ____ Hoarseness
32 - ____ Breathing irregular
33 - ____ Pulse slow; feels "irregular"
34 - ____ Gagging reflex slow
35 - ____ Difficulty swallowing
36 - ____ Constipation, Diarrhea alternating
37 - ____ "Slow starter"
38 - ____ Get "chilled" infrequent
39 - ____ Perspire easily
40 - ____ Circulation poor, Sensitive to cold
41 - ____ Subject to colds, Asthma, bronchitis

Group Three

42 - ____ Eat when nervous
43 - ____ Excessive appetite
44 - ____ Hungry between meals
45 - ____ Irritable before meals
46 - ____ Get "shaky" if hungry
47 - ____ Fatigue, eating relieves
48 - ____ "Lightheaded" if meals delayed
49 - ____ Heart palpitates if meals Missed or delayed
50 - ____ Afternoon headaches
51 - ____ Overeating sweets upsets
52 - ____ Awaken after few hours sleep - hard to get back to sleep
53 - ____ Crave candy or coffee In afternoons
54 - ____ Moods of depression - "blues" or melancholy
55 - ____ Abnormal craving for Sweets or snacks

Group Four

56 - ____ Hands and feet go to sleep Easily, numbness
57 - ____ Sigh frequently, "air hunger"
58 - ____ Aware of "breathing heavily"
59 - ____ High altitude discomfort
60 - ____ Opens windows in closed room
61 - ____ Susceptible to colds and fevers
62 - ____ Afternoon "yawner"
63 - ____ Get "drowsy" often
64 - ____ Swollen ankles Worse at night
65 - ____ Muscle cramps, worse during Exercise: get "charley horses"
66 - ____ Shortness of breath on exertion
67 - ____ Dull pain in chest or radiating into left arm, worse on exertion
68 - ____ Bruise easily, "black and blue" spots
69 - ____ Tendency to anemia
70 - ____ "Nose bleeds" frequent
71 - ____ Noises in head, or "ringing in ears"
72 - ____ Tension under the breastbone, or feeling of "tightness"' worse on exertion

Group Five

73 - ____ Dizziness
74 - ____ Dry skin
75 - ____ Burning feet
76 - ____ Blurred vision
77 - ____ Itching skin and feet
78 - ____ Excessive falling hair
79 - ____ Frequent skin rashes
80 - ____ Bitter, metallic taste in mouth in mornings
81 - ____ Bowel movements painful or difficult
82 - ____ Worrier, feels insecure
83 - ____ Feeling queasy; headache over eyes
84 - ____ Greasy foods upset
85 - ____ Stools light-colored
86 - ____ Skin peels on foot soles
87 - ____ Pain between shoulder blades
88 - ____ Use laxatives
89 - ____ Stools alternate from soft to watery
90 - ____ History of gallbladder attacks or gallstones
91 - ____ Sneezing attacks
92 - ____ Dreaming, nightmare type bad dreams
93 - ____ Bad breath (halitosis)
94 - ____ Milk products cause distress
95 - ____ Sensitive to hot weather
96 - ____ Burning or itching anus
97 - ____ Crave sweets

Group Six

98 - ____ Loss of taste for meat
99 - ____ Lower bowel gas several hours after eating
100 - ____ Burning stomach sensations, eating relieves
101 - ____ Coated tongue
102 - ____ Pass large amounts of foul-smelling gas
103 - ____ Indigestion ½ - 1 hour after
104 - ____ Mucous colitis or "irritable bowel"
105 - ____ Gas shortly after eating
106 - ____ Stomach "bloating eating; may be up to 3-4 hours after

Group Seven

(A)

107 - ____ Insomnia
108 - ____ Nervousness
109 - ____ Cant't gain weight
110 - ____ Intolerance to heat
111 - ____ Highly emotional
112 - ____ Flush easily
113 - ____ Night sweats
114 - ____ Thin, moist skin
115 - ____ Inward trembling
116 - ____ Heart palpitates
117 - ____ Increased appetite without gain
118 - ____ Pulse fast at rest
119 - ____ Eyelids and face twitch
120 - ____ Irritable and restless
121 - ____ Can't work under pressure

(B)

122 - ____ Increase in weight
123 - ____ Decrease in appetite
124 - ____ Fatigue easily
125 - ____ Ringing in ears
126 - ____ Sleepy during day
127 - ____ Sensitive to cold
128 - ____ Dry to scaly skin
129 - ____ Constipation
130 - ____ Mental sluggishness
131 - ____ Hair coarse, falls out
132 - ____ Headaches upon arising wear off during day
133 - ____ Slow pulse, below 65
134 - ____ Frequency of urination
135 - ____ Impaired hearing
136 - ____ Reduced initiative

(C)

137 - ____ Failing memory
138 - ____ Low blood pressure
139 - ____ Increased sex drive
140 - ____ Headaches, "splitting or rendering" type
141 - ____ Decreased sugar tolerance

(D)

142 - ____ Abnormal thirst
143 - ____ Bloating of abdomen
144 - ____ Weight gain around hips or waist
145 - ____ Sex drive reduced or lacking
146 - ____ Tendency to ulcers, colitis
147 - ____ Increased sugar tolerance
148 - ____ Women: menstrual disorders
149 - ____ Young girls: lack of menstrual function

(E)

150 - ____ Dizziness
151 - ____ Headaches
152 - ____ Hot flashes
153 - ____ Increased blood pressure
154 - ____ Hair growth on face or body (female)
155 - ____ Sugar in urine (not diabetes)
156 - ____ Masculine tendencies (female)

(F)

157 - ____ Weakness, dizziness
158 - ____ Chronic fatigue
159 - ____ Low blood pressure
160 - ____ Nails, weak, ridged
161 - ____ Tendency to hives
162 - ____ Arthritic tendencies
163 - ____ Perspiration increase
164 - ____ Bowel disorders
165 - ____ Poor circulation
166 - ____ Swollen ankles
167 - ____ Crave salt
168 - ____ Brown spots or bronzing of skin
169 - ____ Allergies - tendency to asthma
170 - ____ Weakness after colds, influenza
171 - ____ Exhaustion - muscular and nervous
172 - ____ Respiratory disorders

Group Eight

173 - _____ Apprehension
174 - _____ Irritability
175 - _____ Morbid fears
176 - _____ Never seems to get well
177 - _____ Forgetfulness
178 - _____ Indigestion
179 - _____ Poor appetite
180 - _____ Craving for sweets
181 - _____ Muscular soreness
182 - _____ Depression; feelings of dead
183 - _____ Noise sensitivity
184 - _____ Acoustic hallucinations
185 - _____ Tendency to cry without reason
186 - _____ Hair is coarse and/or thinning
187 - _____ Weakness
188 - _____ Fatigue
189 - _____ Skin sensitive to touch
190 - _____ Tendency toward hives
191 - _____ Nervousness
192 - _____ Headache
193 - _____ Insomnia
194 - _____ Anxiety
195 - _____ Anorexia
196 - _____ Inability to concentrate; confusion
197 - _____ Frequent stuff nose; sinus infections
198 - _____ Allergy to some foods
199 - _____ Loose joints

Female Only

200 - _____ Very easily fatigued
201 - _____ Premenstrual tension
202 - _____ Painful menses
203 - _____ Depressed feelings before menstruation
204 - _____ Menstruation excessive and prolonged
205 - _____ Painful breasts
206 - _____ Menstruate too frequently
207 - _____ Vaginal discharge
208 - _____ Hysterectomy/ovaries removed
209 - _____ Menopausal hot flashes
210 - _____ Menses scanty or missed
211 - _____ Acne, worse at menses
212 - _____ Depression of long standing

Male Only

213 - _____ Prostate trouble
214 - _____ Urination difficult or dribbling
215 - _____ Night urination frequent
216 - _____ Depression
217 - _____ Pain on inside of legs or heels
218 - _____ Feeling of incomplete bowel evacuation
219 - _____ Lack of energy
220 - _____ Migrating aches and pains
221 - _____ Tire too easily
222 - _____ Avoids activity
223 - _____ Leg nervousness at night
224 - _____ Diminished sex drive

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DENTAL QUESTIONNAIRE

1) Do you brush your teeth at least twice daily? Yes ☐ No ☐
2) Do you floss regularly? Yes ☐ No ☐
3) Do you have silver mercury fillings in your mouth? Yes ☐ No ☐
4) If you answered "yes," how many fillings do you have? _____
5) How old are your fillings? _____
6) Are any of your fillings cracked, chipped or damaged? Yes No If so, for how long? _____
7) Have you ever swallowed a piece of broken or chipped filling? Yes ☐ No ☐
8) Do you have any crowns? Yes ☐ No ☐
9) If you answered "yes," how many crowns do you have? _____
10) What type of crowns do you have? Gold _____ Porcelain With Gold Base _____ Other _____
11) Do you have any bridges or other dental appliances in your mouth? Yes ☐ No ☐
12) If you answered "yes," please explain _____

_____
13) Do you wear dentures? Yes ☐ No ☐
15) Do you have any root canals? Yes ☐ No ☐
16) If you answered "yes," how many root canals do you have? _____
17) Have you had any teeth extracted due to abscess or infection? Yes ☐ No ☐
18) Have you ever taken antibiotics for a dental abscess, infection or root canal work? Yes ☐ No ☐