
A Self-Assessment Health Questionnaire

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | |
| Gender: | Male ☐ Female ☐ Age: | Height: | Weight: |
| Email Address: | | Date: | |
| Home Address: | | City: | State: |
| Zip Code: | Country: | Province: | |
| Home Phone # ( ) | | Cell Phone # ( ) | |

Your Counselor may recommend Glandulars to *'power punch'* certain areas. Please select your preference for Glandular recommendations: **Preferred** ☐ **Not Preferred** ☐

Please Choose One:
I currently use Dr. Morse's Formulas ☐
I used Dr. Morse's Formulas in the past ☐
I have never used Dr. Morse's Formulas before ☐

## Vitals:

If you are unsure of any of these readings, you may leave them blank.

Blood Pressure: **Right:** **Left:** Eye Color: Brown ☐ Blue ☐

Resting Pulse: Basal Temp. Urine pH: Saliva pH:

How Many Bowel Movements do You Have Daily? **0** ○ **1-2** ○ **3-4** ◉ **4 or more** ○

## Are you taking any medications? Please list individually below:

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

## Are you taking any Herbal Products or Supplements? Please list individually below:

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

## What does your current daily diet consist of?

Please be as honest as possible.

Breakfast:

Lunch:

Dinner:

Snack:

What are your primary health concerns?

What do you hope to gain from this program?

## Genetic / Family History

Please list all known health concerns for each family member. Leave blank if you aren't sure.

Mother:

Father:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Sister/Brother:

Sister/Brother:

Sister/Brother:

Sister/Brother:

## Previous Surgical Procedures

Please list all surgical procedures, minor or major, along with the year

Year:

Year:

Year:

Year:

Year:

## Do you, or have you ever had difficulty with any of the following?

Please circle all applicable, and indicate: Current, Past, or N/A

### Thyroid/ Glandular System

| | | | | | | |
|---|---|---|---|---|---|---|
| Cold Hands or Feet | Current | ☐ | Past | ☐ | N/A | ☐ |
| Frequently Cold / Difficulty Warming | Current | ☐ | Past | ☐ | N/A | ☐ |
| Cold, but Burning Inside? | Current | ☐ | Past | ☐ | N/A | ☐ |
| Easy to Gain Weight and Hard to Lose It | Current | ☐ | Past | ☐ | N/A | ☐ |
| Irregular Heart Beat / Arrythmia's (Also Adrenals/Cardiovascular) | Current | ☐ | Past | ☐ | N/A | ☐ |
| Headaches / Migraines | Current | ☐ | Past | ☐ | N/A | ☐ |
| Easily Irritable | Current | ☐ | Past | ☐ | N/A | ☐ |
| Overweight | Current | ☐ | Past | ☐ | N/A | ☐ |
| Low Energy / Always Tired | Current | ☐ | Past | ☐ | N/A | ☐ |
| Goiter ☐ Hashimoto's ☐ Grave's ☐ Reidel's Disease ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| **Family Member** with: Goiter ☐ Hashimoto's ☐ Grave's ☐ Reidel's Disease ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| How Much do You Sweat? | Low | ☐ | Medium | ☐ | Excessive | ☐ |

### Parathyroid

| | | | | | | |
|---|---|---|---|---|---|---|
| Are Your Fingernails: (Check all Applicable) | Ridged | ☐ | Brittle | ☐ | Weak | ☐ |
| Varicose Veins ☐ Spider Veins ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Hemorrhoids ☐ Prolapses ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Muscle Cramps / Legs Tire Easily | Current | ☐ | Past | ☐ | N/A | ☐ |
| Is Your Bladder: | Strong | ☐ | A Few Leaks | ☐ | Weak | ☐ |
| Hernia | Current | ☐ | Past | ☐ | N/A | ☐ |
| Aneurysm | Current | ☐ | Past | ☐ | N/A | ☐ |
| Low Bone Density ☐ Low Calcium ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Osteoporosis ☐ Scoliosis ☐ Kyphosis ☐ Lordosis ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Mental Health Challenges (Depression, PTSD, OCD, etc.) Please List: | Current | ☐ | Past | ☐ | N/A | ☐ |
| Spinal Deterioration ☐ Herniated Discs ☐ Bone Spurs ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Bruise Easy | Current | ☐ | Past | ☐ | N/A | ☐ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Pancreas | Slow Digestion | Current ☐ | Past ☐ | N/A ☐ |
| | Food Passes Quickly Through You (Diarrhea) | Current ☐ | Past ☐ | N/A ☐ |
| | Acid Reflux ☐ Heartburn ☐ Indigestion ☐ | Current ☐ | Past ☐ | N/A ☐ |
| | Undigested Food in Stool | Current ☐ | Past ☐ | N/A ☐ |
| | Thin / Difficulty Gaining Weight | Current ☐ | Past ☐ | N/A ☐ |
| | Moles (Also Adrenals) | Current ☐ | Past ☐ | N/A ☐ |
| Adrenals (Glandular System) | Overweight | Current ☐ | Past ☐ | N/A ☐ |
| | MS ☐ ALS ☐ Parkinson's ☐ Palsey ☐ | Current ☐ | Past ☐ | N/A ☐ |
| | Anxiety | Current ☐ | Past ☐ | N/A ☐ |
| | Excessive Shyness / Inferiority Complex | Current ☐ | Past ☐ | N/A ☐ |
| | Tremors / Nervous Legs | Current ☐ | Past ☐ | N/A ☐ |
| | High Blood Pressure (Also Cardiovascular) | Current ☐ | Past ☐ | N/A ☐ |
| | Low Blood Pressure | Current ☐ | Past ☐ | N/A ☐ |
| | Hypoglycemia (Low Blood Sugar) | Current ☐ | Past ☐ | N/A ☐ |
| | Diabetes: **TYPE I** ☐ **TYPE 2** ☐ | Current ☐ | Past ☐ | N/A ☐ |
| | Tinnitis (Ringing in Ears) | Current ☐ | Past ☐ | N/A ☐ |
| | Difficulty Taking Deep Breath / S.O.B (Shortness of Breath) | Current ☐ | Past ☐ | N/A ☐ |
| | Cardiac Arrythmia : (Also Cardiovascular) Please List Which Type: | Current ☐ | Past ☐ | N/A ☐ |
| | Sleep Challenges: Difficulty Getting to Sleep (Also Pineal) | Current ☐ | Past ☐ | N/A ☐ |
| | Sleep Challenges: Difficulty Staying Asleep (Also Pituitary) | Current ☐ | Past ☐ | N/A ☐ |
| | CFS (Chronic Fatigue Syndrome) | Current ☐ | Past ☐ | N/A ☐ |
| | Addison's Disease ☐ Congenital Adrenal Hyperplasia ☐ | Current ☐ | Past ☐ | N/A ☐ |
| | High Cholesterol | Current ☐ | Past ☐ | N/A ☐ |
| | Do You Have *any* "Itis" Condition (Arthritis, Osteoarthritis, Bursitis, etc) Please List: | Current ☐ | Past ☐ | N/A ☐ |
| | Low Steroids / Low Cortisol | Current ☐ | Past ☐ | N/A ☐ |
| | ADD ☐ ADHD ☐ Autism ☐ | Current ☐ | Past ☐ | N/A ☐ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Females Only | Are You Currently Pregnant? | Yes | ☐ | | | No | ☐ |
| | Are You Currently Breastfeeding? | Yes | ☐ | | | No | ☐ |
| | Irregular Menses (Also Pituitary) | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Excessive Bleeding During Menstruation | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Ovarian Cysts ☐ Fibroids ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Endometriosis ☐ A-Typical Cells ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Fibrocystic Breasts | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Sore or Painful Breasts, Especially During Menstruation | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Low ☐ Excessive ☐ Sex Drive | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Have You Had a Complete Hysterectomy Partial Hysterectomy | Current | ☐ | Past | ☐ | N/A | ☐ |
| | If Yes, Were Any Other Organs / Lymph Nodes Removed? Please List Which: | | | | | | |
| | Difficulty Conceiving | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Birth Control Pills? For How Long: | Current | ☐ | Past | ☐ | N/A | ☐ |
| Males Only | Do You Have Prostatitis? How Often do You Urinate? | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Have You Been Diagnosed With Prostate 'Cancer'? | Current | ☐ | Past | ☐ | N/A | ☐ |
| | What are Your PSA's? | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Testicular Hypertrophy (Enlarged Testicles) | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Low ☐ Excessive ☐ Sex Drive | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Erection Problems | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Premature Ejaculation | Current | ☐ | Past | ☐ | N/A | ☐ |
| Gastro-Intestinal Tract | Bowel Movements per Day: | 0 - 1 ○ | | 2 ○ | | 3 ○ | | 4+ ○ |
| | Crohn's ☐ Colitis ☐ Gastritis ☐ Enteritis ☐ Diverticulitis ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Gastroparesis (Paralysis of the Stomach) | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Hiatus Hernia | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Coated Tongue, Especially Upon Waking: (white, yellow, green, brown) | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Diarrhea ☐ Constipation ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Stomach ☐ Intestinal ☐ Ulcers | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Gastro-Intestinal 'Cancer': Please Provide Location of 'Cancer': | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Gas Problems (Also Pancreas) | Current | ☐ | Past | ☐ | N/A | ☐ |
| | Other GI Issues Not Listed: | Current | ☐ | Past | ☐ | N/A | ☐ |

## Liver / Gallbladder / Blood

| | | | |
|---|---|---|---|
| Difficulty Digesting Fats | Current ☐ | Past ☐ | N/A ☐ |
| Fats or Dairy Cause Stomach Bloat / Pain | Current ☐ | Past ☐ | N/A ☐ |
| Light Colored or White Stools | Current ☐ | Past ☐ | N/A ☐ |
| Pain Mid-Back (Especially After Eating) | Current ☐ | Past ☐ | N/A ☐ |
| 'Liver' or Brown Spots (Not Freckles) | Current ☐ | Past ☐ | N/A ☐ |
| Skin Pigmentation Irregularities or Changes (Also Pituitary) | Current ☐ | Past ☐ | N/A ☐ |
| Jaundice of Eyes / Skin | Current ☐ | Past ☐ | N/A ☐ |
| Anemia | Current ☐ | Past ☐ | N/A ☐ |
| Hepatitis A ☐ B ☐ or C ☐ | Current ☐ | Past ☐ | N/A ☐ |

| | | | | |
|---|---|---|---|---|
| | | Daily | Weekly | Monthly or Less |
| Alcohol Consumption: | Don't Drink ○ | ○ | ○ | ○ |

## Cardiovascular

| | | | |
|---|---|---|---|
| Angina / Chest Pain | Current ☐ | Past ☐ | N/A ☐ |
| Myocardial Infarction (Heart Attack) | Current ☐ | Past ☐ | N/A ☐ |
| Pacemaker ☐ Stents ☐ Other Open Heart Surgery ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Do You Feel Pressure on Your Chest? | Current ☐ | Past ☐ | N/A ☐ |
| Do You Feel 'Prickly' Pains? Please List Where: | Current ☐ | Past ☐ | N/A ☐ |

## Skin

| | | | |
|---|---|---|---|
| Blemishes ☐ Rashes ☐ Acne ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Dermatitis ☐ Eczema ☐ Psoriasis ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Dry, Itchy Skin | Current ☐ | Past ☐ | N/A ☐ |
| Excessively Oily Skin | Current ☐ | Past ☐ | N/A ☐ |
| Dandruff | Current ☐ | Past ☐ | N/A ☐ |
| Any Other Skin Problems: Please List: | Current ☐ | Past ☐ | N/A ☐ |

| | | |
|---|---|---|
| Do You Have Any Tattoos? | Yes ○ | No ○ |

## Lymphatic System

| | | | | | | |
|---|---|---|---|---|---|---|
| Hair Loss ☐ Balding ☐ Fully Bald (not by choice) ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Have You Ever Had Any Lymph Nodes Removed? | Yes ◯ | No ◯ |
| From Which Area of Your Body Were They Removed? | N/A ☐ |
| How Many Were Removed? | N/A ☐ |
| Swollen Lymph Nodes ☐ Lymphedema ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Do You Have Edema (Fluid Retention)? Please Provide Location: | Current ☐ | Past ☐ | N/A ☐ |
| Fibromyalgia ☐ Scleroderma ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Cold & Flu-like Symptoms | Current ☐ | Past ☐ | N/A ☐ |
| Sore Throat / Sinus Problems | Current ☐ | Past ☐ | N/A ☐ |
| Poor Memory / Brain Fog | Current ☐ | Past ☐ | N/A ☐ |
| Blurred Vision | Current ☐ | Past ☐ | N/A ☐ |
| Mucus in Eyes Upon Waking | Current ☐ | Past ☐ | N/A ☐ |
| Have You Been Diagnosed With 'Cancer' ? Please Provide Location: | Current ☐ | Past ☐ | N/A ☐ |
| Other Type of Non-Malignant Mass / Tumor: | Fatty ☐ | Benign ☐ | N/A ☐ |
| Location of Non-Malignant Mass / Tumor: | N/A ☐ |
| AIDS / HIV + | Current ☐ | Past ☐ | N/A ☐ |
| Low Platelet Count (Also Cardiovascular) | Current ☐ | Past ☐ | N/A ☐ |
| Appendicitis / Appendectomy | Current ☐ | Past ☐ | N/A ☐ |
| Date of Appendicitis / Appendectomy: | N/A ☐ |
| Date of Tonsillectomy (Tonsils Removed): | N/A ☐ |
| Boils ☐ Pimples ☐ Cysts ☐ Abscesses ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Gout | Current ☐ | Past ☐ | N/A ☐ |
| Toxemia ☐ Cellulitis ☐ | Current ☐ | Past ☐ | N/A ☐ |
| Sleep Apnea | Current ☐ | Past ☐ | N/A ☐ |
| Do You Snore? | Current ☐ | Past ☐ | N/A ☐ |

## Kidneys & Bladder

| | | | | | | |
|---|---|---|---|---|---|---|
| UTI ☐ Bladder Infection ☐ Cystitis ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Burning While Urinating | Current | ☐ | Past | ☐ | N/A | ☐ |
| Weak Bladder / Urinary Incontinence | Current | ☐ | Past | ☐ | N/A | ☐ |
| Restricted Urine Flow | Current | ☐ | Past | ☐ | N/A | ☐ |
| Kidney Stones | Current | ☐ | Past | ☐ | N/A | ☐ |
| Nephritis | Current | ☐ | Past | ☐ | N/A | ☐ |
| Cramping or Pain Mid-to Lower Back on Either Side | Current | ☐ | Past | ☐ | N/A | ☐ |
| Lower Back Weakness | Current | ☐ | Past | ☐ | N/A | ☐ |
| Sciatica | Current | ☐ | Past | ☐ | N/A | ☐ |
| Bags Under Eyes | Current | ☐ | Past | ☐ | N/A | ☐ |

## Respiratory System

| | | | | | | |
|---|---|---|---|---|---|---|
| Bronchitis ☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Pain / Difficulty Breathing | Current | ☐ | Past | ☐ | N/A | ☐ |
| Pain / Difficulty Taking Deep Breaths (Also Adrenals) | Current | ☐ | Past | ☐ | N/A | ☐ |
| Collapsed Lung: Right ☐ Left ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Frequent Cough | Current | ☐ | Past | ☐ | N/A | ☐ |
| Color of Mucus Expectorated: Clear ☐ Yellow ☐ Green ☐ Brown ☐ Black ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Do You Use a : Nebulizer ☐ Inhaler ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| What is Your Oxygen Saturation (or SP02)? | | | | | Don't Know | ☐ |
| Have You Been Diagnosed With Lung 'Cancer'? | Current | ☐ | Past | ☐ | N/A | ☐ |
| Are You a Smoker? | Current | ☐ | Past | ☐ | Never Smoked | ☐ |
| How Much do You Smoke? | Packs/Day: | | or | | Cigarettes/ Day: | |

## Environmental and Other Toxic Exposure

| | | | | | | |
|---|---|---|---|---|---|---|
| Exposure to: Nuclear Wastes & By-Products ☐ Heavy Metals ☐ Toxic Chemicals ☐ | Current | ☐ | Past | ☐ | N/A | ☐ |
| Exposure to Toxic Substances Such as Asbestos or Coal Mines (Also Respiratory System) | Current | ☐ | Past | ☐ | N/A | ☐ |
| Have You Gone Through Chemotherapy or Radiation? | Current | ☐ | Past | ☐ | N/A | ☐ |
| How Many Treatments of Chemo or Radiation? | | | | | | |
| Have You Received the "Standard" Vaccinations? | Yes | ☐ | | | No | ☐ |
| Have You Received the Covid Vaccination? | Yes | ☐ | | | No | ☐ |
| Have You Received a Flu Shot? | Yes | ☐ | | | No | ☐ |
| Have You Ever Used 'Recreational' Drugs? (this information is confidential and used to help you attain optimal health only!) | Current | ☐ | Past | ☐ | N/A | ☐ |
| Please List Any 'Recreational' Drugs You Have Used: | | | | | | |