DEVELOPMENT PROGRAM - RETEST MINERAL ANALYSIS FORM

Name _____ Age _____ Phone number _____ Postal code _____

City _____ State or Province _____ Country _____

Please answer the questions below to help us set up your new program:

1. ***On a scale of 0-5, how closely have you followed your program? 0=not at all 5=perfectly***

   Diet____ Supplements____ Water ____ Lifestyle____ Rest____ Saunas or heat lamp_____

   Pulling Down Exercise____ Reflexology____ Coffee Enemas____ Spinal Twist ____

2. ***What is your current diet? (Please don't fudge on this – I know it can be embarrassing):***

   What are typical Breakfasts? Beverages

   _____ |_____

   _____ |_____

   Mid-morning Snacks_____ |_____

   What are typical lunches? Beverages

   _____ |_____

   _____ |_____

   Mid-afternoon Snacks_____ |_____

   What are typical dinners? Beverages

   _____ |_____

   _____ |_____

3. ***Describe changes you have you noticed in your symptoms over the past several months:***

4. ***Do you have any questions about your supplements, diet program, sauna therapy or coffee enemas?***

5. ***Do you have any questions about emotional aspects, meditation or lifestyle challenges?***

6 ***Are there other concerns you would like us to address when updating your healing program?***

Name _____

SYMPTOM SHEET

Directions: **CIRCLE any conditions that presently describe you. HIGHLIGHT the most important symptoms with the PDF reader**

- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Arthritis, Osteo
- ☐ Arthritis, Rheumatoid
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Muscle Cramps
- ☐ Bursitis
- ☐ Fractures
- ☐ Osteoporosis
- ☐ Gout

- ☐ Sweet Cravings
- ☐ Sugar Reactions
- ☐ Irritable before meals
- ☐ Can't Skip Meals
- ☐ Hypoglycemia
- ☐ Crave Starches
- ☐ Fat Cravings
- ☐ Other Food Cravings
- ☐ Food Allergies
- ☐ Excessive hunger
- ☐ No hunger

- ☐ Diabetes
- ☐ Rapid Heart Rate
- ☐ Skipped Heart Beats
- ☐ Heart Palpitations
- ☐ Heart Attack
- ☐ Poor Circulation
- ☐ Dizziness
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ High Cholesterol_____
- ☐ High Triglycerides_____

- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Post-nasal Drip
- ☐ Sinus Congestion
- ☐ Allergies
- ☐ Emphysema

- ☐ Fatigue
- ☐ Hypothyroidism
- ☐ Low Body Temperature
- ☐ Cold in Winter/Dry Skin
- ☐ Tend to Gain Weight
- ☐ Hyperthyroidism
- ☐ Eye conditions_____

- ☐ Acne
- ☐ Eczema
- ☐ Fungal Infections/Candida
- ☐ Psoriasis
- ☐ Hives
- ☐ Hair Loss
- ☐ Slow Wound Healing
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Meniere's Disease
- ☐ Tooth Decay
- ☐ Excessive Plaque on Teeth
- ☐ Gum Disease

- ☐ Get Infections Easily
- ☐ Epstein-Barr Virus
- ☐ Tumors/Cancer
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Scleroderma
- ☐ Anger
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Brain Fog
- ☐ Confusion

- ☐ Depression
- ☐ Irritability
- ☐ Mind Races
- ☐ Mood Swings
- ☐ Obsessive/Compulsive
- ☐ Panic Attacks
- ☐ Poor Memory
- ☐ Suicidal thoughts
- ☐ Schizophrenia
- ☐ Trouble Sleeping
- ☐ Autism
- ☐ Attention Deficit
- ☐ Hyperkinesis
- ☐ Dyslexia
- ☐ Seizures
- ☐ Learning Disability
- ☐ Mental Retardation
- ☐ Delayed Development

- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Trouble Urinating
- ☐ Frequent Urination
- ☐ Painful Urination

- ☐ Sinus Headaches
- ☐ Tension Headaches
- ☐ Migraine Headaches
- ☐ Neuritis

- ☐ Constipation
- ☐ Diarrhea
- ☐ Intestinal Gas
- ☐ Bloating
- ☐ Heartburn
- ☐ Ulcer
- ☐ Stomach Pain
- ☐ Colitis
- ☐ Gall Stones
- ☐ Fissures
- ☐ Hemorrhoids
- ☐ Cirrhosis
- ☐ Diverticulitis
- ☐ Tend to Gain Weight
- ☐ Tend to Lose Weight

- ☐ Anemia
- ☐ Easy Bruising

- ☐ Abuse
- ☐ Drug Addiction
- ☐ Alcoholism
- ☐ Smoking

WOMEN:

- ☐ Premenstrual Syndrome
- ☐ Water Retention
- ☐ Cramps
- ☐ No Menstruation
- ☐ Heavy periods
- ☐ Light Periods
- ☐ Irregular Periods
- ☐ Ovarian Cysts
- ☐ Fibroid Tumors
- ☐ Abnormal Pap Smear
- ☐ Menopause
- ☐ Fibrocystic Breasts
- ☐ Breast Tumors
- ☐ Yeast Infections
- ☐ Hot Flashes

MEN:

- ☐ Prostate Problems
- ☐ Impotence
- ☐ Infertility

Other Symptoms or Comments: _____