3063 STERLING CIRCLE STE 1 BOULDER, CO 80301
WWW.HEALATHEAL.COM
F: 303.440.4346
P: 303.440.HEAL(4325)

HEAL™
Transformation Beyond Healing

Energy Medicine Bay Evaluations

Today's Date: _____

Name: _____ Sex: (M / F)
Street: _____ City: _____ Zip:_____
Phone #: (H) (____) _____ (W) (____) _____ (C) (____) _____
Email: _____ DOB: ____/____/____ Age: _____ Ht: ____ Wt: ____

Married / Divorced / Single / Widowed / Separated / Partnered (circle one) Place of Birth: _____
Emergency Contact's Name and Phone #: _____
Occupation: _____
Occupational Stresses (Chemical, physical, psychological, etc.): _____
_____
_____
Referred by: _____ Physician: _____ Phone: _____
Main Concern/health issue:
List your top 3 main complaints and circle the ONE you want us to focus on during the evaluation
(1) _____
(2) _____
(3) _____
Recent Exams: (give dates)
Physical: _____ Eye: _____ Dental: _____
Ob/Gyn: _____ Specialist:_____
What is your philosophy of health care?: _____
Do you have health questions that do not get answered at the doctor's office?: (Y / N)
_____
_____

During your Bay Evaluation, we will be evaluating four areas that are usually the cause of any illness/injury; structural, chemical, emotional and energetic.

STRUCTURAL

1. Please list all physical pain and complaints you are currently experiencing.
Please circle: headaches / shoulders / neck / mid-back / low back / arm / elbow / hand / leg / knee / hip / feet

_____
_____
_____

CHEMICAL

1. Describe all forms of chemical stress you have been exposed to as part of your employment or lifestyle.

_____
_____
_____

continued on next page

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Please fill out the following questions and check the internal organ systems that are out of balance. **Instructions:** Below is a list of conditions which may seem unrelated to the purpose of your session. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now.)

Gastro-intestinal

Acute	Chronic	
_____	_____	Digestive Complaints
_____	_____	Stomach Pain
_____	_____	Ulcers
_____	_____	Frequent Heartburn
_____	_____	Nausea
_____	_____	Frequent Diarrhea
_____	_____	Frequent Constipation
_____	_____	Irritable Bowel
_____	_____	Hemorroids
_____	_____	Frequent Vomiting
_____	_____	Colitis / Diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder Trouble
_____	_____	Frequent Burping/Belching

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle Cramps / Muscle Spasms
_____	_____	Neck Pain
_____	_____	Jaw Pain
_____	_____	Dizziness
_____	_____	Back Pain
_____	_____	Shoulder / Elbow / Wrist Pain (circle one)
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee Pain / Hip Pain (circle one)
_____	_____	Joint Pain or loss of function
_____	_____	Osteoporosis / Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis / Bursitis

Immune Response

Acute	Chronic	
_____	_____	Frequently Sick
_____	_____	Frequent swollen glands/sore throats
_____	_____	Depression and/or Anxiety
_____	_____	Achy Joints / Muscle Pain
_____	_____	Headaches/migraines
_____	_____	Recurrent Digestive Complaints
_____	_____	Chronic Fatigue
_____	_____	Food Allergies
_____	_____	Eczema or Hives

Cardiovascular

Acute	Chronic	
_____	_____	Irregular Heartbeat
_____	_____	Heart Murmur/Palpitations
_____	_____	High or Low Blood Pressure
_____	_____	Chest Pain
_____	_____	Previous Heart Trouble
_____	_____	Poor Circulation
_____	_____	Previous Heart Surgery
_____	_____	Varicose or Spider Veins
_____	_____	Hands and Feet cold all the time

Respiratory

Acute	Chronic	
_____	_____	Chronic Cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent Head Colds
_____	_____	Recurrent Sinus Infections
_____	_____	Recurrent Bronchitis
_____	_____	Smoker

Genito-Urinary

Acute	Chronic	
_____	_____	Too Frequent Urination
_____	_____	Discolored or foul smellin urine
_____	_____	Blood in urine
_____	_____	Recurrent Kidney or Bladder Infections
_____	_____	Kidney Stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Eyes / Ears

Acute	Chronic	
_____	_____	Recurrent Ear Infections
_____	_____	Eye Infection
_____	_____	Slowly Losing Vision
_____	_____	Floater in Eyes
_____	_____	Glaucoma
_____	_____	Macular Degeneration
_____	_____	Cataracts
_____	_____	Diabetic Retinopathy

Miscellaneous

Acute	Chronic	
_____	_____	Difficulty Sleeping
_____	_____	Restless / Uneasy Sleep
_____	_____	Edema
_____	_____	Unusual swelling in arms or legs

For Men Only

Acute	Chronic	
_____	_____	Prostate Trouble
_____	_____	Urination Problems
_____	_____	Reproductive Problems

Patient Name: _____ Date: _____

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Endocrine (Glandular)

Acute	Chronic	
_____	_____	Cold Hands and Feet
_____	_____	Low Blood Pressure
_____	_____	Weight Problems (over or under)
_____	_____	Thyroid Problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety / Nervousness / Irritabilty
_____	_____	Dizzy upon standing too quickly
_____	_____	Weak and Shaky
_____	_____	Hyperactive Behavior
_____	_____	Depression
_____	_____	Very susceptible to infections
_____	_____	Frequent Headaches
_____	_____	Digestive Complaints

For Women Only

Acute	Chronic	
_____	_____	Recurrent urinary tract infections
_____	_____	Yeast Infections
_____	_____	Vaginal Discharge
_____	_____	Menstrual Irregularity
_____	_____	Cramping
_____	_____	Mood Swings / Depression
_____	_____	Pre-menstrual Syndrome
_____	_____	Infertility
_____	_____	Frequent Miscarriages
_____	_____	Hot Flashes
_____	_____	Currently taking hormone medication
_____	_____	Currently taking birth control pills
_____	_____	Lumps in Breasts
_____	_____	Uterine Cysts / Ovarian Cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis

List Nutritional Supplements you are presently taking:

_____

_____

_____

List Prescription Medication you are presently taking:

_____

_____

_____

List foods you love to eat: _____

List foods you like to eat: _____

List foods you avoid or cannot eat/tolerate: _____

EMOTIONAL

Describe any significant mental or emotional stress you have encountered in the past or present.

_____

_____

_____

_____

ENERGETIC

Please describe any energetic disturbances or insults you are experiencing now or in the past:

_____

_____

_____

_____

_____

_____

_____

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Chief Complaint Worksheet

Symptom/Complaint: _____

Onset (What caused it & When did it begin?): _____

Provoke (What worsens the complaint: position, activity, stress, food/drinks, motion, etc.?): _____

Palliative (What makes it better: ice, massage, position?): _____

Quality (Describe what you feel. Is it sharp/dull, burning/aching, throbbing/constant, stabbing/shooting, pinpoint/general): _____

Radiation (Does the pain travel from one area to another?): _____

Reference: What is the worse pain you've ever experienced?: _____

Severity:

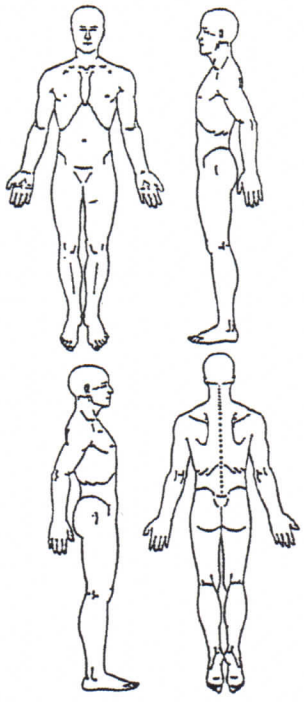
At Its Worse:
0 1 2 3 4 5 6 7 8 9 10
Percent of time: _____

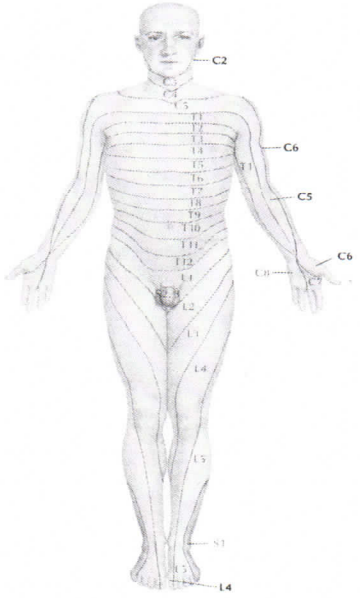
At Its Best:
0 1 2 3 4 5 6 7 8 9 10
Percent of time: _____

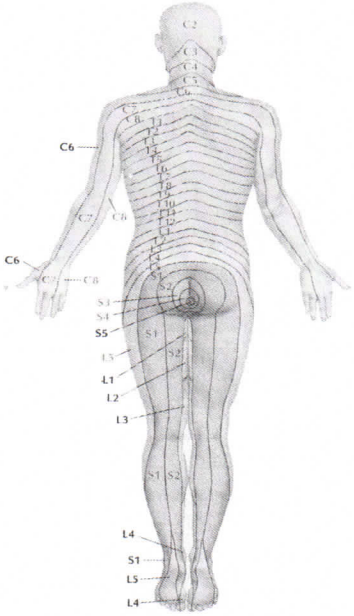
Timing: (Is the pain constant or intermittent? Has the pain occurred before? Does it change with time of day or day of week?): _____

Possible Hospitalization Correlation: _____
Possible Infection Correlation: _____
Possible Traumatic Correlation: _____
Possible Surgical Correlation: _____
Possible Medication Correlation: _____
Possible Genetics Correlation: _____

Please mark where you have pain or symptoms. Write down how it feels, such as deep or surface, stabbing or dull, throbbing or constant:







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Metabolic Assessment Form

Name: _____ Age: _____ Sex: (M / F) Date: _____

Please list the 5 major health concerns in your order of importance:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely 0 1 2 3
Lower abdominal pain relief by passing stool or gas .. 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Diarrhea 0 1 2 3
Constipation 0 1 2 3
Hard, dry, or small stool 0 1 2 3
Coated tongue of "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Use laxatives frequently 0 1 2 3

Category II

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following a meal 0 1 2 3
Offensive breath 0 1 2 3
Diffi cult bowel movements 0 1 2 3
Sense of fullness during and after meals 0 1 2 3
Difficulty digesting fruits and vegetables;
undigested foods found in stools 0 1 2 3

Category III

Stomach pain, burning, or aching 1- 4
hours after eating 0 1 2 3
Use antacids
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down or bending forward 0 1 2 3
Temporary relief from antacids, food,
milk, carbonated beverages 0 1 2 3
Digestive problems subside with rest and relaxation . 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus,
peppers, alcohol, and caffeine 0 1 2 3

Category IV

Roughage and fiber cause constipation 0 1 2 3
Indigestion and fullness lasts 2-4
hours after eating 0 1 2 3
Pain, tenderness, soreness on left side
under rib cage 0 1 2 3
Excessive passage of gas 0 1 2 3
Nausea and/or vomiting 0 1 2 3
Stool undigested, foul smelling,
mucous-like, greasy, or poorly formed 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category V

Greasy or high-fat foods cause distress 0 1 2 3
Lower bowel gas and or bloating 0 1 2 3
several hours after eating 0 1 2 3
Bitter metallic taste in mouth,
especially in the morning 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternates from clay colored
to normal brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry or flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you had your gallbladder removed 0 1 2 3

Category VI

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep yourself going or started .. 0 1 2 3
Get lightheaded if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Feel shaky, jittery, or have tremors 0 1 2 3
Agitated, easily upset, nervous 0 1 2 3
Poor memory/forgetful 0 1 2 3
Blurred vision 0 1 2 3

Category VII

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets does not relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category VIII

Cannot stay asleep 0 1 2 3
Crave salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails 0 1 2 3

Category IX

Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under high amounts of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep ... 0 1 2 3
Excessive perspiration or perspiration with 0 1 2 3
little or no activity 0 1 2 3

Patient Name: _____ Date: _____

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Category X

Tired, sluggish 0 1 2 3
Feel cold - hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight gain even with low-calorie diet ... 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression, lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face, or genitals or excessive falling hair 0 1 2 3
Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XI

Heart palpitations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional 0 1 2 3
Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XII

Diminished sex drive 0 1 2 3
Menstrual disorders or lack of menstruation 0 1 2 3
Increased ability to eat sugars without symptoms 0 1 2 3

Category XIII

Increased sex drive 0 1 2 3
Tolerance to sugars reduced 0 1 2 3
"Splitting" type headaches 0 1 2 3

Category XIV (Males only)

Urination diffi culty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel evacuation 0 1 2 3
Leg nervousness at night 0 1 2 3

Category XV (Males only)

Decrease in libido 0 1 2 3
Decrease in spontaneous morning erections 0 1 2 3
Decrease in fullness of erections 0 1 2 3
Diffi culty in maintaining morning erections 0 1 2 3
Spells of mental fatigue 0 1 2 3
Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decrease in physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XVI (Menstruating Females Only)

Are you perimenopausal ..... (Y / N)
Alternating menstrual cycle lengths ..... (Y / N)
Extended menstrual cycle, greater than 32 days ..... (Y / N)
Shortened menses, less than every 24 days ..... (Y / N)
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne breakouts 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____
Since menopause, do you ever have uterine bleeding? (Y / N)
Hot flashes 0 1 2 3
Mental fogginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Acne 0 1 2 3
Increased vaginal pain, dryness or itching 0 1 2 3

How many alcoholic beverages do you consume per week?
_____

How many caffeinated beverages do you consume per day?
_____

How many times do you eat out per week? _____
How many times a week do you eat raw nuts or seeds? _____
How many times a week do you eat fish? _____
How many times a week do you workout? _____

List the three worst foods you eat during the average week:
_____,
_____,
_____

List the three healthiest foods you eat during the average week:
_____,
_____,
_____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week:
(1 2 3 4 5 6 7 8 9 10)

Patient Name: _____ Date: _____

continued on next page

Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: (M / F) Date: _____

Please circle the appropriate number "0 - 3" on all questions below.

0 as the least/never to 3 as the most/always.

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SECTION A

Is your memory noticeably declining? 0 1 2 3
Are you having a hard time remembering names 0 1 2 3
and phone numbers?.....0 1 2 3
Is your ability to focus noticeably declining?.....0 1 2 3
Has it become harder for you to learn things? 0 1 2 3
How often do you have a hard time remembering
your appointments?.....0 1 2 3
Is your temperament getting worse in general?.....0 1 2 3
Are you losing your attention span endurance? 0 1 2 3
How often do you fi nd yourself down or sad?.....0 1 2 3
How often do you fatigue when driving compared
to the past? 0 1 2 3
How often do you fatigue when reading compared
to the past? 0 1 2 3
How often do you walk into rooms and forget why?
.....0 1 2 3
How often do you pick up your cell phone and forget why?
.....0 1 2 3

SECTION B

How high is your stress level? 0 1 2 3
How often do you feel that you have something that
must be done? 0 1 2 3
Do you feel you never have time for yourself? 0 1 2 3
How often do you feel you are not getting enough
sleep or rest? 0 1 2 3
Do you fi nd it diffi cult to get regular exercise?.....0 1 2 3
Do you feel uncared for by the people in your life?
.....0 1 2 3
Do you feel you are not accomplishing your life's purpose?
.....0 1 2 3
Is sharing your problems with someone difficult for you?
.....0 1 2 3

SECTION C

SECTION C1

How often do you get irritable, shaky, or have lightheadedness
between meals? 0 1 2 3
How often do you feel energized after eating? 0 1 2 3
How often do you have difficulty eating large
meals in the morning?.....0 1 2 3
How often does your energy level drop in the afternoon?
.....0 1 2 3
How often do you crave sugar and sweets in the afternoon?
.....0 1 2 3
How often do you wake up in the middle of the night?
.....0 1 2 3
How often do you have diffi culty concentrating before eating?
.....0 1 2 3
How often do you depend on coffee to keep yourself going?
.....0 1 2 3
How often do you feel agitated, easily upset, and nervous
between meals? 0 1 2 3

SECTION C2

Do you get fatigued after meals?.....0 1 2 3
Do you crave sugar and sweets after meals? 0 1 2 3
Do you feel you need stimulants such as coffee after meals?
.....0 1 2 3
Do you have diffi culty losing weight? 0 1 2 3
How much larger is your waist girth compared to your hip girth?
.....0 1 2 3
How often do you urinate? 0 1 2 3
Have your thirst and appetite been increased? 0 1 2 3
Do you have weight gain when under stress? 0 1 2 3
Do you have difficulty falling asleep?.....0 1 2 3

SECTION 1 - S

Are you losing your pleasure in hobbies and interests?
.....0 1 2 3
How often do you feel overwhelmed with ideas to manage?
.....0 1 2 3
How often do you have feelings of inner rage (anger)?
.....0 1 2 3
How often do you have feelings of paranoia? 0 1 2 3
How often do you feel sad or down for no reason?.....0 1 2 3
How often do you feel like you are not enjoying life?
.....0 1 2 3
How often do you feel you lack artistic appreciation?...0 1 2 3
How often do you feel depressed in overcast weather? .0 1 2 3
How much are you losing your enthusiasm for your favorite
activities? 0 1 2 3
How much are you losing enjoyment for your favorite foods?
.....0 1 2 3
How much are you losing your enjoyment of friendships and
relationships? 0 1 2 3
How often do you have diffi culty falling into deep restful sleep?
.....0 1 2 3
How often do you have feelings of dependency on others?
.....0 1 2 3
How often do you feel more susceptible to pain? 0 1 2 3
How often do you have feelings of unprovoked anger? ..0 1 2 3
How much are you losing interest in life?.....0 1 2 3

SECTION 2 - D

How often do you have feelings of hopelessness? 0 1 2 3
How often do you have self-destructive thoughts? 0 1 2 3
How often do you have an inability to handle stress?....0 1 2 3
How often do you have anger and aggression while under stress?
.....0 1 2 3
How often do you feel you are not rested even after long hours
of sleep?.....0 1 2 3
How often do you prefer to isolate yourself from others?
.....0 1 2 3
How often do you have unexplained lack of concern for family
and friends?.....0 1 2 3
How easily are you distracted from your tasks?.....0 1 2 3
How often do you have an inability to fi nish tasks?.....0 1 2 3
How often do you feel the need to consume caffeine to stay
alert?.....0 1 2 3
How often do you feel your libido has been decreased?.0 1 2 3
How often do you lose your temper for minor reasons? .0 1 2 3
How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

How often do you feel anxious or panic for no reason?..0 1 2 3
How often do you have feelings of dread or impending doom?

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.....0 1 2 3
How often do you feel knots in your stomach?.....0 1 2 3
How often do you have feelings of being overwhelmed for no reason?.....0 1 2 3
How often do you have feelings of guilt about everyday decisions? 0 1 2 3
How often does your mind feel restless?.....0 1 2 3
How diffifi cult is it to turn your mind off when you want to relax? 0 1 2 3
How often do you have disorganized attention? 0 1 2 3
How often do you worry about things you were not worried about before?.....0 1 2 3
How often do you have feelings of inner tension and inner excitability?.....0 1 2 3

SECTION 4 - ACH

Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
Do you feel your verbal memory is decreased? 0 1 2 3
Do you have memory lapses?.....0 1 2 3
Has your creativity been decreased? 0 1 2 3
Has your comprehension been diminished?.....0 1 2 3
Do you have diffi culty calculating numbers?.....0 1 2 3
Do you have diffi culty recognizing objects & faces?.....0 1 2 3
Do you feel like your opinion about yourself has changed? 0 1 2 3
? Are you experiencing excessive urination?.....0 1 2 3
Are you experiencing slower mental response? 0 1 2 3

Patient Name: _____ Date: _____