Golden Key Health

A Self-Assessment Health Questionnaire

First Name:		Last Initial:	
Gender: Male ☐ Female ☐ Age:		Height:	Weight:
Email Address:		Skype Name:	
City:		State:	
Country:	Province:		
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 Vaccinations for Travelling to Foreign Countries?	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:						