REGISTRATION FORM ____________ DATE: _____________

(Fill in **Block Letters.** Fax to: 949-218-9135 or return by Priority Mail). **Do not write above this line.**

Name: _______________________________________ Birth Date :______________

Sex: M / F Age: _______ years Height : __________ Weight : ___________ Lbs.

Vegetarian / Meat Eater Smoking: Yes / No Alcohol: ______________

Any Weight Increase / Decrease in _________ Years / Months ____________ Lbs.

Profession : ____

Job Responsibilities: ____

Exposure to Computers : Yes / No : Years : _________ HRS / DAY:__________

Address : ____

____

City: ____________________________ State: ________ Zip: _______________

Tel: Home: ____________________________ Work : ________________________

E-mail: _______________________________________

Exposure to Chemicals at place of work at any time in the past : Yes / No. Describe :

____

____

____

____

____

Work Address : ____

____

____

____

Referred to our Health Center by: ____
(Name of Publication where you learnt about us / referring Individual / Doctor / Clinic).

If you have Weak Eye Sight tell us about it:

____

If you are a Female, tick all Symptoms given below that apply:

PMS / Cramps	Irregular cycles	Hot / Cold Flashes
Menopausal symptoms	Lowered libido	Bone loss (Osteoporosis)
Headaches / Migraines	Breast tenderness	Swollen feet / ankle
Mood swings / Depression	Panic / Weeping	Vaginal dryness
Inability to lose weight	Blood Sugar imbalance	Hair loss
Fatigue	Leg / Muscle cramps	Fibrocystic Breast
Foggy thinking / Memory loss	Feelings of being crazy	Anger / Irritability
Lost interest in sex	Hysteria	Uterine fibroids
Water retention / bloating	Allergies	Age and Liver spots
Low blood sugar	Facial hair	Dry aging skin
Adult acne	Low Thyroid symptoms	Insomnia
Lower Back Pains	Sciatica (Lower Back / Leg Pain)	Spondylitis (Upper Back Pain)

Any Other ____

Do you have: Irregular Periods / Non Ovulating Cycles / Have the number of days of flow reduced to less than typical 4 day period normally encountered in most women:

____

Year of: Puberty __________ **Menopause** ________ **Hysterectomy** __________

If you are a Male, tick all Symptoms given below that apply:

Difficulty Passing Urine	Enlarged Prostate	Incontinence
Impotence	Erectile Dysfunction	Lack of Sex Drive
Prostate Inflammation	Lowered Libido	Prostate Cancer
Headaches / Migraines	Burning Sensation Urinating	Breast Enlargement
Mood swings / Depression	Panic / Weeping	Rapid Weight loss
Inability to lose weight	Blood Sugar Imbalance	Hair loss
Fatigue	Leg / Muscle Cramps	Hypoglycemia
Foggy thinking / Memory loss	Feelings of being crazy	Anger / Irritability
Lack of interest in Sex	Hysteria	Bone loss (Osteoporosis)
Water retention / Bloating	Allergies	Age and Liver spots
Low Blood Sugar	Swollen feet / ankle	Dry aging skin
Adult Acne	Low Thyroid symptoms	Insomnia
Reduced Muscular Strength	Low Sperm Count	Diabetes
Lower Back Pains	Sciatica (Lower Back / Leg Pain)	Spondylitis (Upper Back Pain)

Any Other ____

Enlarged Prostate: Yes / No Describe: ________________________________

For all Males & Females:

Your Medical History :

____

____

____

History of Constipation / Impotence / Lack of Sex Drive / Urinary Problems :

____

____

Present Symptoms :

____

____

____

____

____

Chronic Health / Beauty Challenges you would like to overcome :

____

____

____

If you use a Pacemaker, Defibrillator or at Pregnant please inform us now before you start treatment for Spondylitis or Sciatica / Pain Relief / Vita Flex Therapy.

____

Please provide overleaf a List of Medications that you presently take or have taken in the past .

I certify that the facts herein are true and correct. I am willing to participate in any Research Program you may have for my Chronic Health / Beauty Challenges through Natural means. I understand that this Research Program is not intended to replace Conventional Medicine, but rather to complement and enhance it. If symptoms persist or are severe, I will consult a competent medical professional immediately. I understand that all Health and Beauty Care Counseling I receive is given to me with the best of intentions. I assume all responsibilities for my actions today and in the future and hold all others harmless.

Date: ___________________ ___________________________

Participant's Signature

Please provide a list of Medicines that you presently take or have taken in the past:

(If you need to list more items, please Xerox this page and attached extra pages as required.)

1	Brand Name	
	Chemical Name	
	Tablet Size / mg	
	Dose	
	Duration / Years / Months	
	For What Ailments	

2	Brand Name	
	Chemical Name	
	Tablet Size / mg	
	Dose	
	Duration / Years / Months	
	For What Ailments	

3	Brand Name	
	Chemical Name	
	Tablet Size / mg	
	Dose	
	Duration / Years / Months	
	For What Ailments	

4	Brand Name	
	Chemical Name	
	Tablet Size / mg	
	Dose	
	Duration / Years / Months	
	For What Ailments	

5	Brand Name	
	Chemical Name	
	Tablet Size / mg	
	Dose	
	Duration / Years / Months	
	For What Ailments	

Remarks :