Health History & Payment Form

PLEASE COMPLETE THE REQUESTED INFORMATION, PAYMENT INFORMATION AND SEND BACK WITH SPECIMEN

Name:_____ **Date:**_____

Address:_____

_____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Please enter the doctor, practitioner, person or program **who referred you** for this exam:

_____ or ___ internet ___ other:_____

If needed, who will be treating you?

Date of Birth: _____ ___**Male** ___ **Female**

If you have been to other countries in the past two years please list them:

_____

Date of Stool Collection: _____ **Date Shipped:** _____

Stool Was: ___ **Hard** ___ **Soft** ___ **Mushy** ___ **Liquid** ___ **Abnormal Smell**

___ **Blood in Stool** ___ **Mucus in Stool**

Circle all that apply:

Multiple Sclerosis Arthritis Lupus Asthma Kidney Disease Liver Disease

COPD Emphysema Prostate Problems Esophageal Reflux Stomach Issues

Bloating Excessive Gas Abdominal Cramping Abdominal Pain Diarrhea

Constipation Irritable Bowel Crohn's Disease Ulcerative Colitis Hemorrhoids

Colon/Rectal Polyps Blood in Stool Weight Loss Candida Gall Bladder Issue

Leukemia Lymphoma Lyme Dementia Muscle Pain Low Immunity Depression

Urinary Tract issues Brain Fog Fatigue Skin issues Thyroid issues HIV-AIDS

Other Medical Condition(s): _____

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If You Have/Had Cancer:

Type: _____ Location: _____Stage:_____
(breast, colon, etc.)
If spread, to what tissues:_____

Treatments (circle): None Surgery Medical Radiation Radiation Hormesis

Chemotherapy Immunotherapy Acupuncture PolyMVA IV Therapies

Herbal Medicines Vitamins/Minerals Out-Of-Country Therapies

Other:_____

If You Have/Had Cancer:

I have been told that I am: ___ in remission ___ cured ___ cannot be cured

If applicable, I have been told I have ( ) weeks months years to live

Is there anything you would like to share about your health or health goals?

Acceptable Forms of Payment In US Dollars Are:

Check (Personal, Company, Cashiers, Money Order) Drawn on a US Bank

Credit Card (MasterCard, Visa, Discover, American Express)

Fee for the INITIAL PARASITE EVALUATION: $297 RETEST FEE: $200

___ Check: Make payable to "C.H.I.M." [Center for Holistic & Integrative Medicine]

___ Credit Card: Visa MasterCard Discover American Express

Payment will appear on your credit card statement as:
Center for Holistic & Integrative Medicine

Card Number: _____

Expiration Date: _____

Three Digit Security Code: _____

Name on Card: _____

Signature of Cardholder: _____

Reminder

Enclose stool and urine specimens in its zip lock bag with the absorbent towel and place in smaller white box. Place the smaller box into the larger brown box along with This Form and the signed Application to be a Research Associate. Tape up the outer box and ship as soon as possible after the stool collection. Shipping methods: Priority US Mail, UPS or FedEx.
Address for Shipping: Dr. d'Angelo, 18121 East Hampden Ave, Unit C-123, Aurora, CO 80013
Allow 10-14 days turnaround time for results.

Thank you.