

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: _____

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 Are:**

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

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

Fee for the Parasitology Consultation: \$297 [US Dollars]

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

\_\_\_ Credit Card: Visa MasterCard Discover American Express

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 from receipt of specimens for turnaround time for results.

Thank you.