Health History & Payment Form

Please complete the requests for: 1) Health History information, 2) Payment information, 3) Membership Agreement (first time member) - send back with your specimens.

Please Print Full Name Legibly, or use a mailing return address label.

Patient
Name:_____Date:_____
*Guardian's Name If applicable:*_____
Address:_____
City:_____ State:_____ Zip_____
Phone: _____
Email address:_____
Date of Birth_____ Male ( ) Female ( )

Who referred you for this exam?_____

Who will be treating you?_____

Date of Stool/Urine Collection_____ Date Shipped_____

Stool Was: ( ) Hard ~ ( ) Soft ~ ( ) Mushy ~ ( )Liquid ~
( )Abnormal Smell ~ ( ) Blood in Stool ~ ( ) Mucus in Stool

If you have been to other countries in the past, please list them:
_____
_____
_____

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/Pain ~ Diarrhea ~ Constipation ~ Irritable Bowel ~ Crohn's Disease ~Ulcerative Colitis ~ Hemorrhoids ~ Colon/Rectal Polyps ~ Blood in Stool ~Weight Loss ~ Candida ~ Gall Bladder Issues ~ Leukemia ~ Lymphoma ~ Lyme ~ Dementia ~ Muscle Pain ~ Low Immunity ~ Depression ~ Urinary Tract issues ~ Brain Fog ~ Fatigue ~ Skin issues ~ Thyroid issues ~ HIV-Aids ~ SIBO ~ Adrenal Issue
Other Medical Conditions: *Please feel free to continue on the other side.*

Office Use Only

New Test Re-Test
New Member

Member Number:

Date Received:
_____
Date Notified:_____
Email Phone

Invoice
#:_____
( )Credit Card ( )Check
Invoice Sent:_____E M

Report Sent:_____

_____

Retest ( ) ( ) ( )

Date_____Inv_____

Notes:

~*~ *TURN PAGE OVER* ~*~

If You Have / Had Cancer:

Type:_____ Location:_____Stage:_____

If spread, to what tissues:_____

Treatments (circle): None ~ Surgery ~ Medical Radiation ~ Radiation Hormesis
Chemotherapy ~ Immunotherapy ~ Acupuncture ~ PolyMVA ~ IV Therapies ~ Out of country treatment
Other:_____

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

Acceptable Forms of Payment Are: [Note: Insurance cannot be used for testing]

Check (personal, company, cashiers) drawn on a US Bank
Credit Card (MasterCard, Visa, Discover, American Express)

( ) Fee for the INITIAL Parasitology Evaluation : $297.00
( ) Retest: (all retests are in one calendar year of initial test) $250.00
( ) Membership fee (one time) **must be member for testing** $10.00

( ) Check: Make payable to "C.H.I.M." [Center for Holistic & Integrative Medicine]
( ) Credit Card [y**our cc statement will show "Center for Holistic…"**]

Card number: _____ Expiration Date:_____

Name on card: (please print)_____Security Code_____

Signature of Cardholder: _____

Reminder:

Enclose stool and urine specimens wrapped with the absorbent paper towels in its zip lock bag and place in smaller white box. Place the smaller white box into the larger brown box along with **this form**, the **signed application for membership for first time members**. Tape the outer box and ship as soon as possible after the stool collection. Shipping methods: Priority US Mail, UPS or FedEx. Do Not send overnight, it's not necessary. When packed as indicated above no postal lab pack or biohazard declaration is required.

Mail Service Address for Shipping: Dr. d'Angelo, 18121 East Hampden Ave, C-123, Aurora, CO 80013

Once the specimen arrives in our LAB, (not mail service address) you'll be emailed. Please allow 10-14 days for testing and release of report.