

**APPLICATION FORM & QUESTIONNAIRE**   
  
  
**GENERAL INFORMATION  
  
  
Today's date:**    
  
**Name:**

**Age:** **Sex (M/F)**   
  
Place of birth:

Date of Birth:

Marital status:

Number of children:

Living situation (alone, family, friends):

Occupation:   
  
**Address:**  
  
City

State/Zip/Country

**E-mail address:**

Fax   
  
**Phone** (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** (work/cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:

**Optional** *(sometimes it can help explain your health problem)*:

Religion:

Race:

**Weight:**

**Height:**

**Any recent weight changes? Gain or loss and when…**

**I am interested in the comprehensive alternative treatment for cancer: Yes No**

*(please indicate below)*

**Gerson Therapy**

**IV Therapy (Vit C & Glutathione)**

**Iscador Therapy**

**Cancer specific supplements**

**I am available to start the program on:**

**I am planning to come alone: Yes No**

**If you are coming with companion: Yes, we share a bed No, we need two separate beds**

**If you are bringing more than one companion, how many in total:**

**COMPREHENSIVE HEALTH HISTORY**

*Please describe your current symptoms and problem areas. Include pain, fatigue, mobility, areas of weakness and of strength.*

*If you have received a diagnosis, please include the diagnosis and date received:*

*Non-cancer related – describe past treatments:*

*Cancer – Note type of cancer, Stage, Metastasis location:*

*Previous personal history of cancer. Please explain.*

*Family history of cancer. Please explain.*

**Treatments**

*Chemotherapy - number of treatments, date and side effects:*

*Radiation – number of sessions, dates and side effects:*

*Surgery- name of procedure and date:*

*Other treatments:*

*Describe treatment results:*

*Do you have a secondary medical condition that is present?*

**Personal Medical History**

***Include: Date Diagnosed & Treatment Taken***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Date diagnosed** | **Treatment** | **Resolved?** |
| High Blood Pressure |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |
| Stroke/Thrombosis |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Liver/Gall Bladder Disease |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |
| Seizure Disorder |  |  |  |  |  |
| Lung Disease |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Emphysema |  |  |  |  |  |
| Other list below: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Do you have any allergies including drug allergies?**

Please list all surgeries (i.e., include cosmetic, implants, biopsies, laser surgery):   
  
**Name of surgical procedure & Year:**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Have you had any blood transfusions? \_\_Yes \_\_No Blood type, if known: \_\_\_\_   
If yes, when? \_\_\_

What is your current stress level (5 high)? \_\_1 \_\_2 \_\_3 \_\_4 \_\_5

Past Occupations: \_\_\_\_

**Toxins**

Have you been exposed to any of the following?   
Agricultural chemicals \_\_Yes \_\_No   
Industrial/Workplace chemicals \_\_Yes \_\_No   
Cigarette smoking \_\_Yes \_\_No   
If yes, how much? \_\_\_ For how long? \_\_\_\_   
Date of last cigarette smoked? \_\_   
Second hand smoke/how much/how long? \_\_\_\_   
Alcohol use? \_\_Yes \_\_No How much? \_\_\_   
Recreational drugs? \_\_Yes \_\_No How much? \_\_\_   
How long? \_\_\_

“Street drugs” \_\_Yes \_\_No If yes, which ones? \_\_\_\_   
  
**Dental History**

Do you have silver mercury fillings? \_\_Yes \_\_No If yes, how many? \_\_\_   
Do you have root canals? \_\_Yes \_\_No If yes, how many? \_\_   
Have you been tested for having metal toxicity?

**Food Issues / Sensitivities**   
  
Do you have any food allergies? \_\_Yes \_\_No   
If yes, please list \_\_\_   
Do any foods give you significant gas, pain, or bloating? \_\_Yes \_\_No   
If yes, please list \_\_\_

Please describe your diet (e.g., fresh organic vegetables and fruit, restaurants 3 times per week, processed foods, white sugar, meat, fish):

**Stomach Disorders or General Digestion Problems**Acid Indigestion \_\_No \_\_Yes, in the past \_\_Yes, currently   
Acid Reflux \_\_No \_\_Yes, in the past \_\_Yes, currently   
Bloating/Flatulence \_\_No \_\_Yes, in the past \_\_Yes, currently   
Colitis \_\_No \_\_Yes, in the past \_\_Yes, currently   
Constipation \_\_No \_\_Yes, in the past \_\_Yes, currently   
Diarrhea \_\_No \_\_Yes, in the past \_\_Yes, currently   
Diverticulitis \_\_No \_\_Yes, in the past \_\_Yes, currently   
Hiatal Hernia \_\_No \_\_Yes, in the past \_\_Yes, currently   
Irritable Bowel Syndrome \_\_No \_\_Yes, in the past \_\_Yes, currently   
Ulcers \_\_No \_\_Yes, in the past \_\_Yes, currently   
  
**Current Medications**

Please list, including Dosage & When you started taking it:  
1. \_\_ \_\_\_   
2. \_\_ \_\_\_   
3. \_\_ \_\_\_   
4. \_\_ \_\_\_   
5. \_\_ \_\_\_   
6. \_\_ \_\_\_   
7. \_\_ \_\_\_   
8. \_\_ \_\_\_   
9. \_\_ \_\_\_   
10. \_\_ \_\_\_   
  
**Note: Please do not discontinue any medications until advised by your Gerson practitioner or private medical doctor.   
  
Please list any supplements, vitamins, or herbs you are taking, including   
Dosage & When you started taking it:**1. \_\_ \_\_\_   
2. \_\_ \_\_\_   
3. \_\_ \_\_\_   
4. \_\_ \_\_\_   
5. \_\_ \_\_\_   
6. \_\_ \_\_\_   
7. \_\_ \_\_\_   
8. \_\_ \_\_\_   
9. \_\_ \_\_\_   
10. \_\_ \_\_\_   
  
**Have you contracted any of the following diseases/infections?   
Sexually Transmitted Diseases**Syphilis \_\_Yes \_\_No   
Gonorrhea \_\_Yes \_\_No   
Genital Herpes \_\_Yes \_\_No   
HPV/Genital Warts \_\_Yes \_\_No   
Chlamydia trachomatis \_\_Yes \_\_No

**Miscellaneous:**Candida albicans \_\_Yes \_\_No   
Trichomonas vaginalis \_\_Yes \_\_No   
Other, please list: \_\_

**Bacterial/viral infections:**Herpes simplex \_\_Yes \_\_No   
Tuberculosis \_\_Yes \_\_No   
Malaria \_\_Yes \_\_No   
Meningitis Viral \_\_Yes \_\_No  
Meningitis Bacterial \_\_Yes \_\_No   
Encephalitis \_\_Yes \_\_No   
Streptococcal \_\_Yes \_\_No   
Staphylococcal \_\_Yes \_\_No   
Septicemia \_\_Yes \_\_No   
Brucellosis \_\_Yes \_\_No   
Candidiasis \_\_Yes \_\_No   
Listeria \_\_Yes \_\_No   
Salmonella \_\_Yes \_\_No   
Camphylobacter \_\_Yes \_\_No   
Helicobacter \_\_Yes \_\_No   
Dysentry \_\_Yes \_\_No   
Hepatitis   
A \_\_Yes \_\_No If yes, when infected? \_\_\_\_   
B \_\_Yes \_\_No If yes, when infected? \_\_\_\_   
C \_\_Yes \_\_No If yes, when infected? \_\_\_\_   
Epstein Barr \_\_Yes \_\_No   
Cytomegalovirus \_\_Yes \_\_No   
  
Other pertinent history or information (please complete):

**Sleep:**

What time do you usually go to bed?

Do you have problems falling asleep?

Do you have any problem staying asleep?

How many hours of sleep do you get?

**Females Only:**

Age at onset of menstruation? \_\_\_   
How many pregnancies? \_\_ Miscarriages \_\_\_ Abortions \_\_\_\_   
Number of children? \_\_\_ Alive \_\_ Deceased \_\_   
How many Cesarean sections? \_\_\_   
Age at onset of menopause? \_\_   
Have you taken oral contraceptive pills? \_\_Yes \_\_No If yes, for how long? \_\_\_\_   
Have you taken Hormone Replacement Therapy (HRT)? \_\_Yes \_\_No   
If yes, for how long? \_\_   
Have you experienced any other of the following (please check)?   
absence of periods \_\_ cervical dysplasia \_\_   
endometriosis \_\_ hemorrhage \_\_   
infection in reproductive organs \_\_ infertility \_\_   
yeast infections \_\_ ovarian cysts \_\_   
premature birth \_\_ still birth \_\_   
diabetes during pregnancy \_\_ pelvic inflammatory disease \_\_   
tubal pregnancy \_\_ toxemia \_\_   
irregular cycle \_\_ placenta previa \_\_   
uterine fibroids \_\_   
  
**Family History**  
Mother: \_\_Alive \_\_Deceased Father: \_\_Alive \_\_Deceased   
Sisters: Number Alive \_\_\_ Number Deceased \_\_\_   
Brothers: Number Alive \_\_\_ Number Deceased \_\_\_   
  
Please insert the names of the family members wherever it applies below. Include mother, father, brothers, sisters, aunts, uncles, grandparents and your children.   
  
High Blood Pressure \_\_Yes \_\_No \_\_\_\_   
Heart Disease \_\_Yes \_\_No \_\_\_\_   
Stroke-Thrombosis \_\_Yes \_\_No \_\_\_\_   
Diabetes \_\_Yes \_\_No \_\_\_\_   
Arthritis \_\_Yes \_\_No \_\_\_\_   
Liver/Gall Bladder Disease\_\_Yes \_\_No \_\_\_\_   
Lung Disease \_\_Yes \_\_No \_\_\_\_   
Asthma \_\_Yes \_\_No \_\_\_\_   
Emphysema \_\_Yes \_\_No \_\_\_\_   
Kidney Disease \_\_Yes \_\_No \_\_\_   
Seizure Disorder \_\_Yes \_\_No \_\_\_\_   
Auto-immune disease \_\_Yes \_\_No \_\_\_\_   
Rheumatoid Arthritis\_\_Yes \_\_No \_\_\_\_   
SLE (Lupus) \_\_Yes \_\_No \_\_\_\_   
Celiac \_\_Yes \_\_No \_\_\_\_   
Chrons \_\_Yes \_\_No \_\_\_\_   
Hyper-thyroidism \_\_Yes \_\_No \_\_\_\_   
Hypo-thyroidism \_\_Yes \_\_No \_\_\_\_   
Multiple Sclerosis \_\_Yes \_\_No \_\_\_\_   
Mental Disease/Depression\_\_Yes \_\_No \_\_\_   
Cancer Type\_\_\_\_Relative\_\_\_   
Type\_\_\_\_Relative\_\_\_   
Type\_\_\_\_Relative\_\_\_   
Type\_\_\_\_Relative\_\_\_   
Other (please complete):

**Social History**   
  
Do you have family/friends for a support system? \_\_Yes \_\_No   
  
Have you recently experienced any losses (i.e., family / friend / job / pet / divorce / financial / mobility / independence)? \_\_Yes \_\_No   
If yes, please explain: \_\_\_   
\_\_\_   
Do you have a spiritual or religious practice, belief system or faith community? \_\_Yes \_\_No \_\_

**Optional Exercise**As an optional self-help exercise, please take a few moments to draw a picture of:   
  
1. How you see yourself in association with your family (stick figures are fine).

2. If you have cancer, please draw a picture of how you see or feel the cancer in your body.

**NOTE: DON'T FORGET TO FILL IN YOUR NAME, ADDRESS, EMAIL & PHONE AT THE TOP. THANK YOU!**

**Hawaii Naturopathic Retreat Center**

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**ESSAY**

**Thank you for completing the Health History Questionnaire. In addition, please write an essay relating to the chronological story of your illness. Include all events preceding the onset of the disease that may have played a role in its development. Include toxic exposure, radiation, mental and emotional issues, relationships, losses- financial or human or animal- unfinished business, grieving process, unfulfilled expectations, set of values, conditioning, or other mental emotional issues. Also include treatments you undertook and the rate of their success. Write about your state of health during these last 20 years, and your projection for the future. Write about the appreciation of your illness as a teacher, what you have learned and what you still have to learn. Write about your will to live and what you would like to accomplish in the future. This essay is a very important step in gathering your strength for healing.**

**MEDICAL RECORDS**

**Send a copy of your diagnosis, most recent laboratory results and imaging studies reports. We need a CBC, a metabolic panel and a urinalysis. If you did not have any blood work done, let us know and we will send you a requisition form.**

*(You will find a medical records release form at the end of this document.)*

**Please return your application by fax to (808) 443-0313.**

**Or, by e-mail to contact2013@hawaiinaturopathicretreat.com.**