HAWAII NATUROPATHIC RETREAT
DETOXIFICATION · LIFESTYLE CHANGES · RAW FOOD · GERSON THERAPY
MAYA NICOLE BAYLAC N.D. License # ND-146
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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

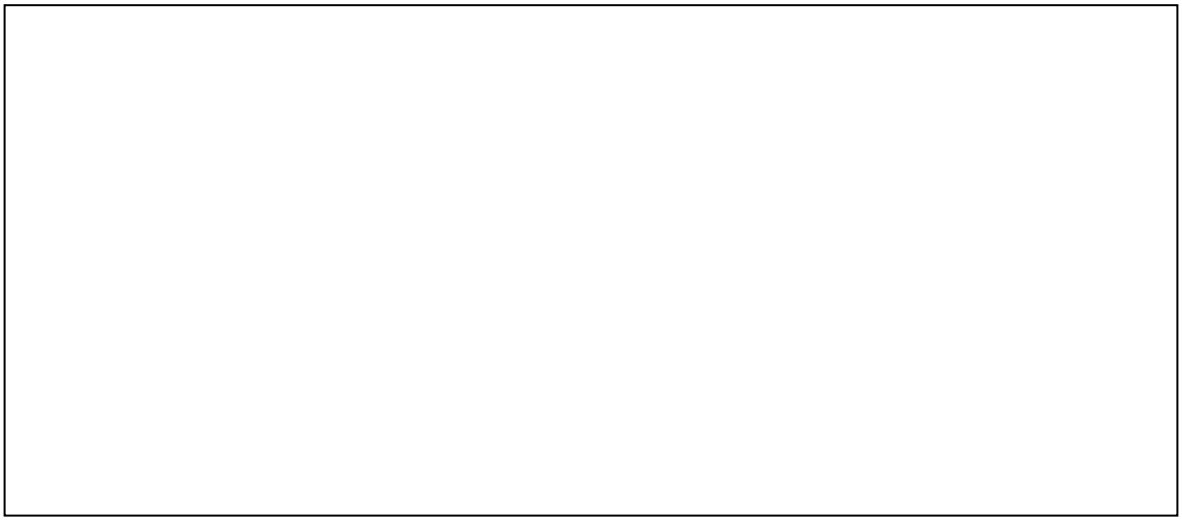
Do you have family/friends for a support system? __Yes __No

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 __

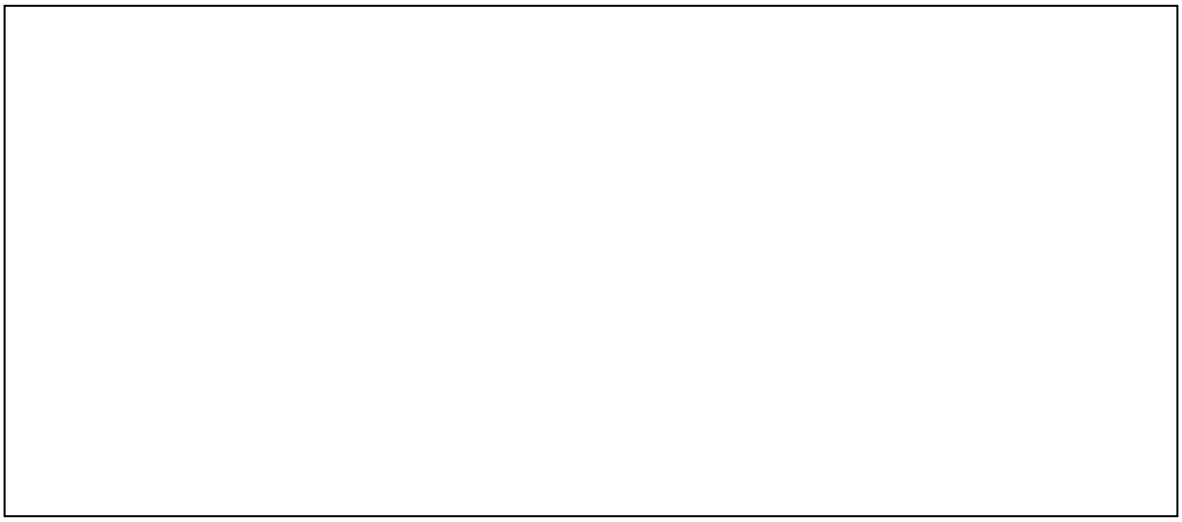
Optional Exercise

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!

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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.