



THE PURE NORTH S'ENERGY FOUNDATION
"Feeling Better, Living Longer"

Pure North Clinical Form

Summary	Priority
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☐ New Participant ☐ Re-GRIP ☐ HIPP ☐ SCP Transfer

Account2, Test22 - 67939

Occupation: _____ (outdoors/indoors - please circle) ☐ Retired

Current Location: _____ Original Location: _____

Contact phone number: _____ Family Physician: _____

Physician Location: _____ Physician Phone/Fax: _____ Release results to Physician: ☐ Yes ☐ No

Past Medical History Tachycardia 2012/04/01 Darier's Disease 2014/01/01 Facial Reconstructive Surgery 2014/01/01 CABG (Coronary Artery Bypass Graft) unknown Basal Cell Carcinoma unknown Carbon Monoxide Poisoning 2004/07/01 Have you had any kidney stones in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes Family History Mother Decreased Lung Capacity unknown Facial Blindness unknown Factor V Leiden unknown Father Facial Blindness 2014/04/01 Calcification 1996/08/01 CCSVI (Chronic Cerebrospinal Venous Insuffic... 1944/04/01 Siblings Decreased Lung Capacity unknown Acid Reflux unknown CABG (Coronary Artery Bypass Graft) unknown Lifestyle Questions Tobacco use: <input type="checkbox"/> Yes: ____ cig. - pk./d ____ yrs <input type="checkbox"/> Never <input type="checkbox"/> Chew <input type="checkbox"/> Quit <1yr >1yr Exercise: <input type="checkbox"/> No <input type="checkbox"/> Yes: ____ / 7 <input type="checkbox"/> cardio <input type="checkbox"/> resistance <input type="checkbox"/> cross <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> strenuous Sleep: <input type="checkbox"/> Well ____ / 10 <input type="checkbox"/> fall <input type="checkbox"/> stay <input type="checkbox"/> enough <input type="checkbox"/> apnea Stress: <input type="checkbox"/> Work ____ / 10 <input type="checkbox"/> Home ____ / 10 Alcohol: ____ average units per week / month Water: ____ g/d Caffeinated Drinks: ____ d-wk. Nutrition: On average do you eat 5 or more servings of fruits and vegetables a day? <input type="checkbox"/> Yes <input type="checkbox"/> No	Chief Complaint / Health Goals blah blah b lah chief complaints??? dddddd akjsdf;kjsd;flkjs ;dfklajs;dkfjas;dkfja;sldkfj a;sldkfj;askldjf;laskdjf ;askldjf ;lksthis is a bunch of really long text so it pushes thyroid quesitons down lbalbhalb alskdf laksfj;aksdjf ;klsdf asdfsdblah blah blah chief complaints??? dddddd akjsdf;kjsd;flkjs ;dfklajs;dkfjas;dkfja;sldkfj a;sldkfj;askldjf;laskdjf ;askldjf ;lksthis is a bunch of really long text so it pushes thyroid quesitons down lbalbhalb alskdf laksfj;aksdjf ;kl Thyroid Questions <input type="checkbox"/> macroglossia <input type="checkbox"/> cool body temperature <input type="checkbox"/> low mood <input type="checkbox"/> unrefreshing sleep <input type="checkbox"/> low energy ____ / 10 <input type="checkbox"/> brain fog <input type="checkbox"/> weight gain <input type="checkbox"/> unrefreshing sleep TOTAL ____ / 7	Biometrics Height (cm) _____ Weight (kg) _____ BMI _____ Waist Girth (cm) _____ Hip Girth (cm) _____ Waist-to-hip ratio _____ BP (mmHg) _____ Saliva pH _____ Fasting Hours _____ Amalgams (current) _____ Amalgams (original) _____ # Root Canals _____ Tooth Extraction (Y/N) _____ Blood Type _____ Oligoscan <input type="checkbox"/> Completed Initials _____																																																																		
	Current Medications Dermovate Felodipine Allergies Sulfa Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplements <table border="1"><thead><tr><th></th><th>Current</th><th>Recommended</th></tr></thead><tbody><tr><td>Vitamin D</td><td>5</td><td>drops/day</td></tr><tr><td>50K Vitamin D</td><td>605</td><td>caps</td></tr><tr><td>MP</td><td>12</td><td>pt/day</td></tr><tr><td>VP</td><td>3</td><td>pt/day</td></tr><tr><td>Omega 3</td><td>3</td><td>cap/day</td></tr><tr><td>NAC/ALA Combo</td><td>0</td><td>tab/day</td></tr><tr><td>B12</td><td>0</td><td>tab/day</td></tr><tr><td>Magnesium</td><td>0</td><td>tab/day</td></tr><tr><td>BB536</td><td>0</td><td>cap/day</td></tr><tr><td>Pro-12</td><td>0</td><td>cap/day</td></tr><tr><td>Caprylic Acid</td><td>0</td><td>tab/day</td></tr><tr><td>Fulvic Minerals</td><td>0</td><td>drops/day</td></tr><tr><td>Raw Materials</td><td>5</td><td>mL/day</td></tr><tr><td>Vit C</td><td>4</td><td>cap/day</td></tr><tr><td>Lypo C</td><td>0</td><td>pt/day</td></tr><tr><td>ReadiSorb</td><td>0</td><td>tsp/day</td></tr><tr><td>Selenium</td><td>7</td><td>cap/day</td></tr><tr><td>Chromium (500 mcg)</td><td>6</td><td>tab/day</td></tr><tr><td>Iodine (100 mcg)</td><td>0</td><td>drops/day</td></tr><tr><td>Niacin</td><td>0</td><td>tab/day</td></tr><tr><td>Others:</td><td></td><td></td></tr></tbody></table>		Current	Recommended	Vitamin D	5	drops/day	50K Vitamin D	605	caps	MP	12	pt/day	VP	3	pt/day	Omega 3	3	cap/day	NAC/ALA Combo	0	tab/day	B12	0	tab/day	Magnesium	0	tab/day	BB536	0	cap/day	Pro-12	0	cap/day	Caprylic Acid	0	tab/day	Fulvic Minerals	0	drops/day	Raw Materials	5	mL/day	Vit C	4	cap/day	Lypo C	0	pt/day	ReadiSorb	0	tsp/day	Selenium	7	cap/day	Chromium (500 mcg)	6	tab/day	Iodine (100 mcg)	0	drops/day	Niacin	0	tab/day	Others:		
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Plan UTM <input type="checkbox"/> Required <input type="checkbox"/> Not Required <input type="checkbox"/> Declined <input type="checkbox"/> Completed Referrals <input type="checkbox"/> Tennant <input type="checkbox"/> Myosymmetries <input type="checkbox"/> HMR	Most Recent 25(OH)D ____ nmol/L Current Dose of Vitamin D ____ IU/d Duration @ above dose ____ days / weeks / months / years NEW RECOMMENDED TOTAL DOSE OF VITAMIN D ____ IU/d																																																																			

Practitioner: _____ Signature: _____ Visit Date: _____