Please pay in advance through the order form.

Then send this form, hair samples and waver through the mail.

You may send the photos along with them or email them.

Send To:

Dr. Alva Irish

236 Fuller Drive

Easley, SC 29640

Your Name _____

Street _____

City _____ State _____ Zip Code _____

Telephone Number (____) _____

Email _____

Physician's Name/Address/Phone:

_____

_____

_____

Medical Diagnosis:

_____

_____

What are your typical days worth of meals?

Breakfast

_____

Snack

_____

Lunch

_____

Snack

_____

Supper

_____

Snack

_____

Prescriptions/Medications you are taking now

_____

_____

Prescriptions taken in the past

_____

_____

Allergies _____

Age _____ Height _____

Weight _____ Blood Pressure _____

Blood Sugar _____

Surgeries? YES NO

If yes above, please explain details

_____

_____

_____

Please list ALL food supplements, vitamins, herbs, etc., you are taking now

_____

_____

Have you ever taken, or are you now taking ANY Homeopathic remedies? YES NO

If so, what were they, when did you take them, how many doses, and what potency of each

_____

_____

List all complaints you have anywhere on your right side, from head to foot

_____

_____

List all complaints you have anywhere on your Left side, from head to foot

_____

_____

Constipation? YES NO

If Yes, please describe the color and consistency, odor _____

Does your abdomen make sounds before? YES NO

Do you have Cramps before? YES NO

Do you have involuntary stool? YES NO

If Yes, when? _____

Do you have involuntary Stools when you urinate? YES NO

When you pass gas? YES NO

Piles? Bleeding? YES NO

When are all your symptoms worse? _____

What makes them better? _____

Any symptoms related to your:

Legs	YES	NO
Arms	YES	NO
Hands	YES	NO
Fingers	YES	NO
Forearms	YES	NO
Wrists	YES	NO
Knees	YES	NO
Achilles Tendons	YES	NO
Feet	YES	NO
Tendons	YES	NO
Leg Cramps	YES	NO

Any of the above - when and where?

_____

Mental Symptoms

Depressed	YES	NO
Elated	YES	NO
Bi-Polar	YES	NO
Seizures	YES	NO

Other Mental Symptoms _____

Head Symptoms _____

Scalp _____

Hair _____

Eruptions/Dandruff/Scabs/Sores/Redness/Scald head: _____

Face/Eyes/Vision _____

Lid Appearance

Swollen	YES	NO
Upper	YES	NO
Lower	YES	NO
Both	YES	NO
Sties	YES	NO
Warts/Growths	YES	NO

Location _____

Do you smoke? YES NO

Use Alcohol? YES NO

Other Drugs? YES NO

Nose Perforated? YES NO

Nose Appearance _____

Ears _____

Hearing _____

Tongue _____

Mouth - Inner _____

Mouth - Lips _____

Throat _____

Uvula _____

Do you snore? YES NO

Sleep Position _____

Are you sleepless? YES NO

Do you want to sleep all the time? YES NO

During the day? YES NO

Are you sleepy after meals? YES NO

Teeth Decay? YES NO

If yes, describe _____

Neck _____

Chest _____

Ribs _____

Heart _____

Veins/Arteries _____

What foods do you HATE? _____

What foods do you CRAVE? _____

What foods do you like, but don't like you? _____

Food allergies _____

Craving odd things, chalk, pencil lead, etc. _____

Stomach _____

Abdomen _____

Liver _____

Spleen _____

Gall Bladder _____

What does your sweat smell like? _____

Feet smell? YES NO

Underarm smell? YES NO

What fears do you have

Cats	YES	NO
Dogs	YES	NO
Rats	YES	NO
Elevators	YES	NO
Riding in cars	YES	NO
Heights	YES	NO
Snakes	YES	NO
Spiders	YES	NO
Birds	YES	NO
Other	YES	NO

Is your furnace new? YES NO

What kind of furnace is it? _____

Do you cook with:

Gas	YES	NO
Electric	YES	NO
Fireplace	YES	NO
Gas/Electric	YES	NO

Ever been exposed to petroleum? YES NO

Describe _____

Do you use petroleum products? YES NO

_____

Are you sensitive to the sun, YES NO if so, what happens?

_____

Are you worse in the HEAT ___ or worse in the COLD_____? What happens?

_____

Do you, or have you ever had cancer? YES NO

If so, where? _____

Do you have a tumor, and if so, where? _____

Warts? Where?

Veneral Warts YES NO

Venereal Disease YES NO

Growths of any kind YES NO

Moles YES NO

Birthmarks YES NO

If any of the above, describe color

_____

Do you have Vitiligo? YES NO

Any other markings on your face?

_____

Do you hate people? YES NO

Would you rather be alone or with people?

_____

Are you worse when you are getting warm in bed? YES NO

After eating sugar? YES NO

During the day or night? YES NO

What happened right before your problems started?

_____

How old were you when your problems started? _____

Tell me what happened _____

_____