

BIO-DATA, L.L.C.
P.O. Box 88 - Hwy 3 at Brown's Creek
Douglas City, CA 96024
(530) 623 - 4644 fax- (530) 623 - 3738
NEW TEST QUESTIONNAIRE

PLEASE READ INSTRUCTIONS CAREFULLY

SALIVA SAMPLE INSTRUCTIONS: The best time to take your saliva sample would be first thing in the morning, before brushing your teeth, eating or drinking anything. We would like to suggest that you participate in a short, aerobic-type 3 minute exercise. **Please contact your current health care professional before starting any exercise routine.** *If possible, PLEASE DO NOT TAKE ANY MEDICATIONS OR HERBS FOR AT LEAST 48 HOURS BEFORE TAKING YOUR SALIVA SAMPLE.* Place a cotton swab under your tongue for a second. Air dry in a non-contaminated area. Place the cotton swab into a small zip-lock bag, **seal and label with your name.** Place the bag into a small envelope and seal. Place it, along with your **completed questionnaire**, into a larger envelope. If you have medications, herbs or vitamins that you would like us to test, please send us properly submitted samples.

Each sample **MUST BE:**

- 1) 2-3 tablets or capsules. (For liquid, put 3-4 drops onto a STERILE cotton ball.)
- 2) Place each sample into a **separate**, clean zip-lock type bag. **CLEARLY LABEL EACH SAMPLE BAG.**
- 3) Place into a padded envelope so contents will not be destroyed during mailing.
- 4) **PLEASE DO NOT MIX ANY SUPPLEMENTS TOGETHER.**
- 5) Due to testing procedures, samples will not be returned.(Extra charge for over 15 samples)

Please fill out the questionnaire as thoroughly as possible.

Please neatly **PRINT** all comments using a **black ink** pen. We want to be able to read and understand what you are telling us. If you have any relevant medical, chiropractic or other health reports please include a copy for our files.

Payment enclosed: Check ___ Money order ___ Amount \$ _____
Bank card # (M/D/V) _____ Exp. _____

NAME: _____ **DATE:** _____

ADDRESS: _____

CITY / STATE / ZIP _____ **COUNTRY:** _____

HOME PHONE:(_____) _____ **WORK:**(_____) _____

FAX:(_____) _____ **CELL PHONE:** (_____) _____

E-mail address _____

SEX: _____ **HEIGHT:** _____ **WEIGHT:** _____ **BIRTH DATE:** _____ **STATUS:** _____

What type of work do you do, or have you done in the past 5 years? _____

What is the primary reason you came to us? _____

Who recommended you to us? _____

Who is your doctor? _____ What type of operations have you had / when? _____

What type of diet do you eat? _____

Please see your current doctor if you have any of these concerns:

1. Advice regarding diagnosis, prognosis or alternative treatments of a medical ailment
2. Monitoring a recognized pathological/disease condition during a period of changing nutritional patterns
3. Examination for the discovery of any latent or potential pathological/disease condition. The purpose of this questionnaire is to assist you in understanding your own health concerns, and to formulate a conservative health plan for you. It may help you to reach your goal of better health.

On the following pages please take the time to consider each section, and mark an "X" in the appropriate column, "P" (past) or "C" (current). If the question does not apply, please skip it and go on to the next.

IMMUNE SYSTEM:

<u>P</u>	<u>C</u>	
___	___	Susceptible to infection?
___	___	Used antibiotics?
___	___	Commonly have fevers?
___	___	Sore throat, nose or mouth?
___	___	Runny nose?
___	___	Redness & Swellings?
___	___	Throat discharge?
___	___	Feeling cold or chilled?
___	___	Indigestion or nausea?
___	___	Achy feeling?
___	___	Lack of energy?
___	___	Elevated white blood cell count?
___	___	Tooth decay?
___	___	Acne?

ENZYME SYSTEM:

___	___	Anemia? Type _____
___	___	Malnutrition syndromes?
___	___	Prone to hemorrhage?
___	___	Under weight?
___	___	Over weight?
___	___	Slow to heal?
___	___	Tired after eating?
___	___	Stomach pain/gas when upset?
___	___	Dependency on antacids?
___	___	Thirsty after eating?
___	___	Bleeding or tender gums?

- Frequent headache?
- Food allergies? _____
- Skin sores / boils?
- Damaged tissue? Where? _____
- Tumors?
 What type? _____
 Where? _____
- Cysts? Where? _____
- Muscular weakness?
- Abdominal bloating?
- Use chemotherapy?

THYROID SYSTEM:

- Sugar causes irritable moods?
- Dry skin?
- Warmer than others?
- Sluggish feeling in morning?
- Mentally sluggish?
- Slow reflexes?
- Hemorrhoids?
- Lack of sex drive?
- Infertility?
- Basil temperature? _____
- Cold hands/feet?
- Swollen/puffy eyes?
- Using thyroid hormones? _____

NERVOUS SYSTEM:

- Insomnia/restless sleep?
- Nervousness?
- Bite fingernails regularly?
- Flashing pains in arms _____ legs _____?
- Gnawing pain in rib cage?
- Muscle spasms?
- Shingles?
- Nerve pain from injury?
- Pains in jaw/face? _____
- Vertigo (dizziness)?
- Numbness in arms _____ legs _____?
- Loss of gripping strength?
- Use drugs to control nerves? _____
- Hyper-pain response?
- Don't like being touched?
- Use pain control therapy? _____

INTESTINAL MOBILITY SYSTEM:

- Constipation?
- Diarrhea?
- Use laxatives? _____
- Bad breath?
- Indigestion 1-3hrs after eating?
- Toxic taste in mouth?

FLUID SYSTEMS: (KIDNEY/LYMPH)

- Urine leakage?
- Bed wetting?
- Drink less than 1 qt water daily? _____
- Lack of urine?
- Calcium in urine?
- Protein in urine?
- Prone to Kidney stones?
- Deep pain inside bottom rib?
- Swelling of Lymph nodes?
- Used Sulfa drugs?
- Excessive thinness?
- Puffiness?
- Dark circles under eyes?
- Swelling around the eyes?
- "Foggy" headed-ness?
- Foul smelling skin?

HEART SYSTEM:

- Use heart medications? _____
- _____
- Valve malfunction?
- Heart flutters/palpitates due to allergic reaction?
- Chest pain when walking?
- Gripping chest pains?
- Heart pounds easily?
- Rapid/irregular heart beat?
- Heart Rate _____ per-min
- Exhaustion with mild exertion?
- Pain in back of head/neck?
- Feeling breathlessness?
- Angina Pectoris?
- B.P.- _____/_____ ?

CANDIDA, PARASITES, FUNGI SYSTEM:

- Mucus in stools?
- Diagnosis of parasites?

- Diagnosis of fungi infestation?
 - Diagnosis of Candida?
 - Peeling or cracking of lips?
 - White patches in mouth?
 - Does mold bother you?
 - Do you feel worse on "muggy" or "damp" days?
 - Do you have any chronic infection of the skin? _____
-

LIVER/GALLBLADDER SYSTEM:

- Eczema?
- Psoriasis?
- Oily skin on face?
- High cholesterol? Count? _____
- Unusual yellow tinge to skin?
- Gray pallor to skin?
- Excessive body odor?
- Bad taste in mouth?
- Prone to gallstones?
- Migraine headaches?
- Yellow stools?
- Slow clotting time?
- Black/"granule" like stools?

PANCREAS/ADRENAL GLANDS:

- Fatigue in mid-morning?
- Fatigue in mid-afternoon?
- Red itching or watery eyes?
- Some foods make you jittery, tired, thirsty or moody?
- Feel shaky/jittery before meals?
- Irritable if meals missed?
- Poor concentration if hungry?
- Have constant thirst?
- Crave sweets?
- Diagnosis of diabetes?
- Need coffee to "get-going"?
- Sunlight bothersome to eyes?
- Momentary dizziness when rising/standing quickly?
- Momentary loss of vision when rising/standing quickly?
- Tightness in throat?
- Dandruff?
- Constantly feeling stressed?
- Feeling sleepy when driving/concentrating?

REPRODUCTIVE SYSTEM - FEMALE:

- Irregular menstruation?
- Feeling weak after menstruation?
- Heavy menstrual bleeding?
- Monthly changes in weight?
- Irritability near periods?
- Imbalanced sex drive?
- Painful/Itching vagina?
- Hot flashes?
- Night sweats?
- Tenderness in breasts?
- Discharge from breasts?
- Take hormone pills? _____
- Pains in ovaries? Right ___ Left ___
- Use birth-control? Which type? _____
- Miscarried? _____
- Hysterectomy? When? _____
- Complete / Partial ? _____
- Pregnant? Due date? _____

REPRODUCTIVE - MALE:

- Impotency?
- Prostate disorders?
- Tenderness in groin?
- Use steroids? _____
- Premature balding?

MUSCLES, JOINTS, BONES & LIGAMENTS:

- Muscle pain/cramping? _____
- Back pains? Where? _____
- Spinal mal-alignment? _____
- Herniated/Slipped disc? _____
- Tendonitis or Tennis elbow? _____
- Weak tendons/ligaments? _____
- Joint pains or stiffness? _____
- Osteoporosis?
- Many cavities?
- Calcium deposits? _____
- Poor calcium balance?
- Use drugs for pain? _____

LIMBIC/EMOTIONAL SYSTEM:

- Intense dreams?
- Unreasonable fears?

- Emotional instability?
- Inability to concentrate?
- Violent temper?
- Slow learning?
- Attention deficit disorder?
- Slurred speech?
- Defensive attitude?
- Lose contact with reality?
- Suicidal tendencies?
- Lack of logical abilities?
- Poor memory?
- Poor communication?
- Use drugs to balance emotions? _____

THE EARS:

- Loss of hearing?
- Ringing in ears?
- Popping in ears?
- Poor balance?
- Motion sickness?
- Noise irritates?
- Withdrawn as child?
- Difficulties in learning speech?
- Hearing device? _____

THYMUS/HISTAMINES SYSTEM:

- Prone to allergies? _____
- Asthma?
- Hyper-active?
- "Flu" like symptoms
- Sneezing or hay fever?
- Use decongestants? _____
- Use anti-histamines? _____
- Have allergy shots?
- Breathe through mouth?
- Itching on roof of mouth?
- Mucus dripping in throat?
- Lung congestion?
- Swollen lips?
- Frequent bladder infections?
- Strong urine smell?
- Bed wetting?

OCULAR (EYE) SYSTEM:

- ___ ___ Wear Glasses /Contacts?
- ___ ___ Colored? what color? _____
- ___ ___ Near sighted?
- ___ ___ Far sighted?
- ___ ___ Astigmatism?
- ___ ___ Night blindness?
- ___ ___ Glaucoma?
- ___ ___ Cataracts?
- ___ ___ Flashing lights in eyes?
- ___ ___ Floaters in eyes?
- ___ ___ Irritated eyes?
- ___ ___ Eyes tire easily?
- ___ ___ Other eye disorders? _____

RESPIRATORY SYSTEM:

- ___ ___ Shortness of breath?
- ___ ___ Rapid/Shallow breathing?
- ___ ___ Deep coughing?
- ___ ___ Rasping sound in lungs?
- ___ ___ Emphysema?
- ___ ___ Prone to bronchitis/laryngitis?

SPLEEN/BLOOD SYSTEM:

- ___ ___ Desire to chew ice?
- ___ ___ Blood cell irregularities? Describe _____
- ___ ___ Paleness of lips?
- ___ ___ Bruise easily?
- ___ ___ Pains inside of bones?
- ___ ___ Take ___ B12? ___ Iron?

ENVIRONMENTAL TOXICITY:

- ___ ___ Drink more than 1 can of soda-pop each week? Quantity. _____
- ___ ___ Use alcohol frequently?
- ___ ___ What type of alcohol & how often? Explain: _____
- ___ ___ Use tobacco products, smoke? _____
- ___ ___ Work in toxic environment? _____
- ___ ___ Exposed to toxic smoke? _____
- ___ ___ Exposed to toxic dust or fumes? _____
- ___ ___ Use scented deodorants/antiperspirant?
- ___ ___ Use cosmetics daily? Explain _____
- ___ ___ Use perfume/cologne/after shave?
- ___ ___ Use cell phones?

- Use pager?
 - Use CB radio?
 - Wear magnetic devices?
 - Have cordless "ether" connections on computer equipment?
 - Ft. How far are you from the nearest power pole?
 - Do you wear any medical electrical aids? _____
-

PLEASE SELECT TYPE OF SCREENING AND HERBS THAT YOU WOULD LIKE: **THIS SECTION MUST BE COMPLETED BE FOR WE CAN SERVE YOU!** Please call if you have questions.

HS-5 - Comprehensive Health Screening. \$118
 Same basic information as noted in HS-3 and HS-4 with a graphical and statistical readout as to the highs and lows in your electrical energy system. This extensive and lengthy screening covers over 40 major areas of the body. Includes a helpful, 1 ½ hr. personal consultation and testing of 15 samples of nutrients, medications, or other substances.

HS-4 - Common Health Screening. \$74
 This will assist you in knowing what nutrition would be most helpful to your body, along with a dietary outline and lymph massage areas. (similar to HS-3). Includes a helpful, 45 min. personal consultation and testing of 15 samples of nutrients, medications or other substances.

HS-3 - Basic Health Screening. \$51
 This will assist you in knowing what nutrition would be most helpful to your body, along with a dietary list, a nutritional screening, specific massage and spinal information. *HS-3 IS NOT RECOMMENDED FOR A FIRST HEALTH SCREENING. THERE IS NO CONSULTATION WITH THE #HS-3. PLEASE SELECT HS-4 OR -5 FOR THIS SERVICE.*

(For a small fee we will be happy to test 15 of your current nutrients or medications with the HS-3)

Your herbal choices are:

- 8 oz Powder Blend \$42
- 16oz Powder Blend \$61
- 32oz Powder Blend \$110
- 8 oz Encapsulated Blend \$61
- 16oz Encapsulated Blend \$89
- 32oz Encapsulated Blend \$162

Prices do not include or shipping/handling charges.

If you would like us to send your herbal blend to you, please indicate here:

YES NO

PERSONAL COMMENTS:

Please describe any other ailments/diseases or conditions that may not be covered in this questionnaire.

Please list any medications (pharmaceutical or not) you are now using.

Within the past 5yrs. _____

Please list type of therapies you are now using _____

Within the past 5yrs. _____

Please feel free to add any additional comments, suggestions or ideas you might have. We would love to hear them. Thank you for taking the time to properly fill out this questionnaire.

Please read & sign the following statement where indicated, if you understand and agree with these legal limitations.

I understand that BIO-DATA, L.L.C. will not cure or heal a disease or condition, give advice regarding diagnosis, prognosis, or treatment, monitor a recognized pathological disease or condition, prescribe products for a condition, or diagnose and treat any allopathic medical ailment or condition. I realize I must go to my medical doctor for these needs. I also realize that BIO-DATA can help me through education, foods, my attitude, exercise and increasing my knowledge on how to improve my environment, thereby helping me increase my natural life force energy.

SIGNATURE: _____ DATE: _____

If you are filling out this questionnaire for someone other than yourself, please note relationship to such person. (parent/guardian) _____

HOW TO ORDER

PHONE ORDERS (NEW CUSTOMER): 530 623 4644

Credit Card orders are accepted by phone. Please have credit card number at hand when calling.

FAX ORDERS: 530 623 3738

Fax your completed and signed order form. Note any address or credit card changes. Fax orders are paid by credit card noted on the order form. Please make sure fax is transmitted. If there is a transmission problem, mark the second fax as “duplicate“.

MAIL ORDERS:

If you prefer to pay by personal or business check, complete the questionnaire order form and mail with your check. Allow time for mail service, processing and product delivery.

CUSTOMER SERVICE 530 623-4644 during business hours.: For inquiries about products, new customer orders or to inquire about orders already placed.

FOR REORDERS ONLY:

E-Mail biodata202@hotmail.com

1. Please give your full name and address for reference. Orders will be shipped to address on file unless changes are noted.
2. Please **DO NOT** give credit card number on e-mail, Call it in. Orders will not be shipped if credit card is declined.
3. Order by stating product #; powder, capsules or tablets; and Quantity wanted.
4. It is important that you call us and let us know about the E-Mail. We do not monitor this mail daily.

METHOD OF PAYMENT:

Visa, MasterCard and Discover credit cards are accepted. Orders are not shipped if credit card is declined. In case of possible electronic transmission error, declined cards are run twice. We will endeavor to call your daytime number about declined cards. If we are unable to reach you by phone, a letter will be mailed.

Personal and business checks accepted. Our insufficient fund charge for returned checks is \$25.00. A credit card, cashiers check or money order **only** will be accepted to cover total of both the returned check and the service charge.

Orders faxed and paid by credit card will be processed and shipped immediately.

FAST SHIPMENTS

We endeavor to process and ship all orders received before 9:00 A. M. within 24 hours. Orders received on Friday, or the day before a holiday, are invoiced and shipped the next business day. Orders are shipped to the address on

file. Please keep your address current. To insure fast delivery, orders should be completely filled out. Average delivery time is generally 2 to 4 business days. With some remote delivery points, postal service may only provide delivery service once or twice a week. Please allow plenty of time for delivery when ordering.

DROP SHIPMENTS

Orders placed and paid for by one person and shipped to another party are considered “drop shipments”. Payment information is posted to the person placing the order. It is up to the individual to confirm that credit cards and other payment information is posted to the correct party and cannot be used by the person receiving the drop shipment.

RETURN POLICY

We will refund any unopened single powder herbs and/or tablets within 30 days of invoice date, upon authorization, by shipping replacement, refund or credit. When returning, please include all needed information with return shipment. **We are unable to refund or accept any returns on any personal food blends.** Personal blends are formulated individually and are only appropriate for the person tested.

NAME AND ADDRESSES ARE CONFIDENTIAL:

All names, addresses and financial information are confidential and are not available to third parties.

SALES/USE TAX

Applicable California sales tax is charged on all California deliveries of non-food products. Herbs are considered as food.

EXPEDITED DELIVERY

Due to our remote location all deliveries are by priority mail. If you have had problems with your order delivery in the past, we offer a delivery confirmation for the current postal fee. This will help reduce additional charges and expedite delivery.

DELAYED, LOST OR DAMAGED SHIPMENTS:

If not at home, the U. S Postal service will endeavor to try three times to make delivery. In some cases, depending upon the delivery area, they may leave your package at your front door; otherwise, they will leave you a note or mail you a notice of attempted delivery. With no response within 5 days, they will return the package to our warehouse.

Because of weather, holidays, and various other reasons, your package may require extra time for delivery. While the postal service is usually very efficient, sometimes packages are incorrectly routed and delayed in shipment. If you feel an insured shipment has been delayed or lost and you reach our voice mail, please leave your full name, daytime phone number, address and request an insured package trace. If we have no record of receiving the order, we will call back for clarification.

If you receive a shipment that is noticeably damaged - refuse the shipment and it will be returned to Bio Data. If the damaged shipment was left at your home while you were out, call your local postal service and advise them that you are refusing the shipment and they will pick it up. Call or fax Bio Data and we will replace all damaged products and handle the Postal service claim.

Orders cannot be canceled after they have been shipped. Customer assumes responsibility for freight costs of undamaged shipments refused and returned. Shipments are sent to address on the order form or the current address in our computer files

**Customer assumes responsibility to keep
shipping address current.**

**HELP US TO HELP OTHERS,
SHARE BIO DATA WITH A FRIEND.**