



Treat the source...not the symptom!

www.MLHWellness.com ph (310) 425-3045 info@mlhwellness.com

Today's Date: _____ Referred by: _____

Name: _____ M F Birthdate: ___/___/___ Age: _____

Email address _____ Address: _____

FIRST TIME EVALUATION

Current Health Complaints: Please rank your current ailments (on a scale of 1 to 10, 10 being most severe)

Other Information: Please list any history of chronic infections and how long you have known about them.

Medications: Please list any you are currently taking and how long you've taken them (including birth control pills, aspirin, pain medication, etc)

Do you smoke? _____ If yes, how much? _____ How long have you smoked? _____

Do you drink? _____ If yes, how much? _____ How often? _____

(This is strictly confidential information) Have you used recreational drugs? Y/ N

Do you still currently use recreational drugs? _____

Do you have any allergies (food or environmental): _____

Dental Work: How many of the following you have OR have had previously (ie replaced metal fillings):

Have you had dental surgery ? [yes/no] Do you need further dental work? [yes/no] If so, what? _____

METAL FILLINGS: _____ PARTIAL OR FULL DENTURES: _____ IMPLANTS GUM: _____ SENSITIVE GUMS: _____
BRACES: _____ BAD BITE: _____ DENTURES? _____ WHITE FILLINGS: _____ EXTRACTIONS: _____
BRIDGEWORK: _____ VENEERS: _____ CROWNS OR INLAYS: _____ [CIRCLE] (GOLD, STAINLESS STEEL,
PORCELAIN, DEGUSSA,) ROOT CANALS: _____ USE A NIGHTGUARD OR INVISALIGN PRIOR/CURRENTLY _____

HEALTH OVERVIEW

SLEEP: What time do you usually go to sleep? _____ Number of hours of sleep per night: _____

How is your sleep? [**Circle:** restless, hard to fall asleep, bad dreams, can't stay asleep.]

How do you feel when you wake up? Rested/Tired Wake up during the night? Y/ N How many times? _____

If so, what time(s) _____ Other complaints related to sleep? _____

5. WOMEN ONLY: Are you pregnant? _____ Are you breast-feeding? _____ Do you have monthly periods?

_____ Date of last menstrual period? _____ Are you going through menopause? _____

Have your periods stopped? _____ Had a hysterectomy? _____ If so, when? _____

Menstrual Cycle: Are your monthly periods regular (28 days)? _____ Number of days of your flow? _____

Pregnancy: Have you ever been pregnant? _____ Number of births _____ Complications? _____

Caesarean/episiotomy? _____

You Have Or Have Had Or Wear:

- | | |
|---|---|
| <input type="checkbox"/> Tempurpedic or Memory Foam Mattress | <input type="checkbox"/> Use Kangen water or some other type of smart water product or reverse osmosis (circle one) |
| <input type="checkbox"/> New car in the last 6 months | <input type="checkbox"/> Use botox/restalyn/juvederm etc. (circle one) how often? _____ |
| <input type="checkbox"/> Aspartame (artificial sweeteners including chewing gum with artificial sweeteners or in your toothpaste) | <input type="checkbox"/> Get chemical peels (how often?) _____ |
| <input type="checkbox"/> Perfume/cologne sprayed over throat area | <input type="checkbox"/> Get laser treatments (how often?) _____ |
| <input type="checkbox"/> Mainly vegetarian diet | <input type="checkbox"/> Breast implants (type _____) |
| <input type="checkbox"/> See other health practitioners regularly | |
| <input type="checkbox"/> Birth control pills (currently or previously-circle one) | |

SYMPTOM SURVEY FORM

NAME _____

DATE _____

AGE _____ SEX M _____ F _____

Phone # (_____) _____

INSTRUCTIONS: Number the boxes which apply to you with either a 1, 2, or 3
 (1) for **MILD** symptoms
 (2) for **MODERATE** symptoms
 (3) for **SEVERE** symptoms
 Leave the box **BLANK** if it does not apply to you!

| GROUP 1 |
|---|
| 1 <input type="checkbox"/> Acid foods upset |
| 2 <input type="checkbox"/> Get chilled, often |
| 3 <input type="checkbox"/> "Lump" in throat |
| 4 <input type="checkbox"/> Dry mouth-eyes-nose |
| 5 <input type="checkbox"/> Pulse speeds after meals |
| 6 <input type="checkbox"/> Keyed up - fail to calm |
| 7 <input type="checkbox"/> Cuts heal slowly |
| 8 <input type="checkbox"/> Gag easily |
| 9 <input type="checkbox"/> Unable to relax; startles easily |
| 10 <input type="checkbox"/> Extremities cold, clammy |
| 11 <input type="checkbox"/> Strong light irritates |
| 12 <input type="checkbox"/> Urine amount reduced |
| 13 <input type="checkbox"/> Heart pounds after retiring |
| 14 <input type="checkbox"/> "Nervous" stomach |
| 15 <input type="checkbox"/> Appetite reduced |
| 16 <input type="checkbox"/> Cold sweats often |
| 17 <input type="checkbox"/> Fever easily raised |
| 18 <input type="checkbox"/> Neuralgia-like pains |
| 19 <input type="checkbox"/> Staring, blinks little |
| 20 <input type="checkbox"/> Sour stomach frequent |

| GROUP 2 |
|---|
| 21 <input type="checkbox"/> Joint stiffness after arising |
| 22 <input type="checkbox"/> Muscle-leg-toe cramps at night |
| 23 <input type="checkbox"/> "Butterfly" stomach, cramps |
| 24 <input type="checkbox"/> Eyes or nose watery |
| 25 <input type="checkbox"/> Eyes blink often |
| 26 <input type="checkbox"/> Eyelids swollen, puffy |
| 27 <input type="checkbox"/> Indigestion soon after meals |
| 28 <input type="checkbox"/> Always seems hungry; feel "lightheaded" often |
| 29 <input type="checkbox"/> Digestion rapid |
| 30 <input type="checkbox"/> Vomiting frequent |
| 31 <input type="checkbox"/> Hoarseness frequent |
| 32 <input type="checkbox"/> Breathing irregular |
| 33 <input type="checkbox"/> Pulse slow; feels "irregular" |
| 34 <input type="checkbox"/> Gagging reflex slow |
| 35 <input type="checkbox"/> Difficulty swallowing |
| 36 <input type="checkbox"/> Constipation, diarrhea alternating |
| 37 <input type="checkbox"/> "Slow starter" |
| 38 <input type="checkbox"/> Get "chilled" infrequently |
| 39 <input type="checkbox"/> Perspire easily |
| 40 <input type="checkbox"/> Circulation poor, sensitive to cold |
| 41 <input type="checkbox"/> Subject to colds, asthma, bronchitis |

| GROUP 3 |
|---|
| 42 <input type="checkbox"/> Eat when nervous |
| 43 <input type="checkbox"/> Excessive appetite |
| 44 <input type="checkbox"/> Hungry between meals |
| 45 <input type="checkbox"/> Irritable before meals |
| 46 <input type="checkbox"/> Get "shaky" if hungry |
| 47 <input type="checkbox"/> Fatigue, eating relieves |
| 48 <input type="checkbox"/> "Lightheaded" if meals delayed |
| 49 <input type="checkbox"/> Heart palpitates if meals missed or delayed |
| 50 <input type="checkbox"/> Afternoon headaches |
| 51 <input type="checkbox"/> Overeating sweets upsets |
| 52 <input type="checkbox"/> Awaken after few hours sleeps - hard to get back to sleep |
| 53 <input type="checkbox"/> Crave candy or coffee in afternoons |
| 54 <input type="checkbox"/> Moods of depression - "blues" or melancholy |
| 55 <input type="checkbox"/> Abnormal craving for sweets or snacks |

| GROUP 4 |
|--|
| 56 <input type="checkbox"/> Hands and feet go to sleep easily, numbness |
| 57 <input type="checkbox"/> Sigh frequently, "air hunger" |
| 58 <input type="checkbox"/> Aware of "breathing heavily" |
| 59 <input type="checkbox"/> High altitude discomfort |
| 60 <input type="checkbox"/> Opens windows in closed room |
| 61 <input type="checkbox"/> Susceptive to colds and fevers |
| 62 <input type="checkbox"/> Afternoon "yawner" |
| 63 <input type="checkbox"/> Get "drowsy" often |
| 64 <input type="checkbox"/> Swollen ankles worse at night |
| 65 <input type="checkbox"/> Muscle cramps, worse during exercise; get "charley horses" |
| 66 <input type="checkbox"/> Shortness of breath on exertion |
| 67 <input type="checkbox"/> Dull pain in chest or radiating into left arm, worse on exertion |
| 68 <input type="checkbox"/> Bruise easily, "black/blue" spots |
| 69 <input type="checkbox"/> Tendency to anemia |
| 70 <input type="checkbox"/> "Nose bleeds" frequent |
| 71 <input type="checkbox"/> Noises in head or "ringing in ears" |
| 72 <input type="checkbox"/> Tension under the breastbone, or feeling of "tightness", worse on exertion |

| GROUP 5 |
|--|
| 73 <input type="checkbox"/> Dizziness |
| 74 <input type="checkbox"/> Dry Skin |
| 75 <input type="checkbox"/> Burning feet |
| 76 <input type="checkbox"/> Blurred vision |
| 77 <input type="checkbox"/> Itching skin and feet |
| 78 <input type="checkbox"/> Excessive falling hair |
| 79 <input type="checkbox"/> Frequent skin rashes |
| 80 <input type="checkbox"/> Bitter, metallic taste in mouth in mornings |
| 81 <input type="checkbox"/> Bowel movement painful or difficult |
| 82 <input type="checkbox"/> Worries, feels insecure |
| 83 <input type="checkbox"/> Felling queasy; headache over eyes |
| 84 <input type="checkbox"/> Greasy foods upset |
| 85 <input type="checkbox"/> Stools light-colored |
| 86 <input type="checkbox"/> Skin peels on foot soles |
| 87 <input type="checkbox"/> Pain between shoulder blades |
| 88 <input type="checkbox"/> Use laxatives |
| 89 <input type="checkbox"/> Stools alternate from soft to watery |
| 90 <input type="checkbox"/> History of gallbladder attacks or gallstones |
| 91 <input type="checkbox"/> Sneezing attaches |
| 92 <input type="checkbox"/> Dreaming, nightmare type bad dreams |
| 93 <input type="checkbox"/> Bad breath (halitosis) |
| 94 <input type="checkbox"/> Milk products cause distress |
| 95 <input type="checkbox"/> Sensitive to hot weather |
| 96 <input type="checkbox"/> Burning or itching anus |
| 97 <input type="checkbox"/> Crave sweets |

GROUP 6

- 98 Loss of taste for meat
- 99 Lower bowel gas several hours after eating
- 100 Burning stomach sensations, eating relieves
- 101 Coated tongue
- 102 Pass large amounts of foul-smelling gas
- 103 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 Mucus colitis or "irritable bowel"
- 105 Gas shortly after eating
- 106 Stomach "bloating" after eating

GROUP 7

(A)

- 107 Insomnia
- 108 Nervousness
- 109 Can't gain weight
- 110 Intolerance to heat
- 111 Highly emotional
- 112 Flush easily
- 113 Night sweats
- 114 Thin, moist skin
- 115 Inward trembling
- 116 Heart palpitates
- 117 Increased appetite without weight gain
- 118 Pulse fast at rest
- 119 Eyelids and face twitch
- 120 Irritable and restless
- 121 Can't work under pressure

(B)

- 122 Increase in weight
- 123 Decrease in appetite
- 124 Fatigue easily
- 125 Ringing in ears
- 126 Sleepy during day
- 127 Sensitive to cold
- 128 Dry or scaly skin
- 129 Constipation
- 130 Metal sluggishness
- 131 Hair coarse, falls out
- 132 Headaches upon arising wear off during day
- 133 Slow pulse, below 65
- 134 Frequency of urination
- 135 Impaired hearing
- 136 Reduced initiative

GROUP 7 (continued)

(C)

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

(D)

- 142 Abnormal thirst
- 143 Bloating of abdomen
- 144 Weight gain around hips or waist
- 145 Sex drive reduced or lacking
- 146 Tendency to ulcers, colitis
- 147 Increased sugar tolerance
- 148 Women: menstrual disorders
- 149 Young girls: lack of menstrual function

(E)

- 150 Dizziness
- 151 Headaches
- 152 Hot flashes
- 153 Increased blood pressure
- 154 Hair growth on face or body (female)
- 155 Sugar in urine (not diabetes)
- 156 Masculine tendencies (female)

(F)

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma
- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

FEMALE ONLY

- 173 Very easily fatigued
- 174 Premenstrual tension
- 175 Painful menses
- 176 Depressed feeling before menstruation
- 177 Menstruation excessive and prolonged
- 178 Painful breasts
- 179 Menstruate too frequently
- 180 Vaginal discharge
- 181 Hysterectomy/ovaries removed
- 182 Menopausal hot flashes
- 183 Menses scanty or missed
- 184 Acne, worse at menses
- 185 Depression of long standing

MALES ONLY

- 186 Prostate trouble
- 187 Urination difficult or dribbling
- 188 Night urination frequent
- 189 Depression
- 190 Pain on inside of legs or heels
- 191 Feeling of incomplete bowel evacuation
- 192 Lack of energy
- 193 Migrating aches and pains
- 194 Tire too easily
- 195 Avoid activity
- 196 Leg nervousness at night
- 197 Diminished sex drive

IMPORTANT

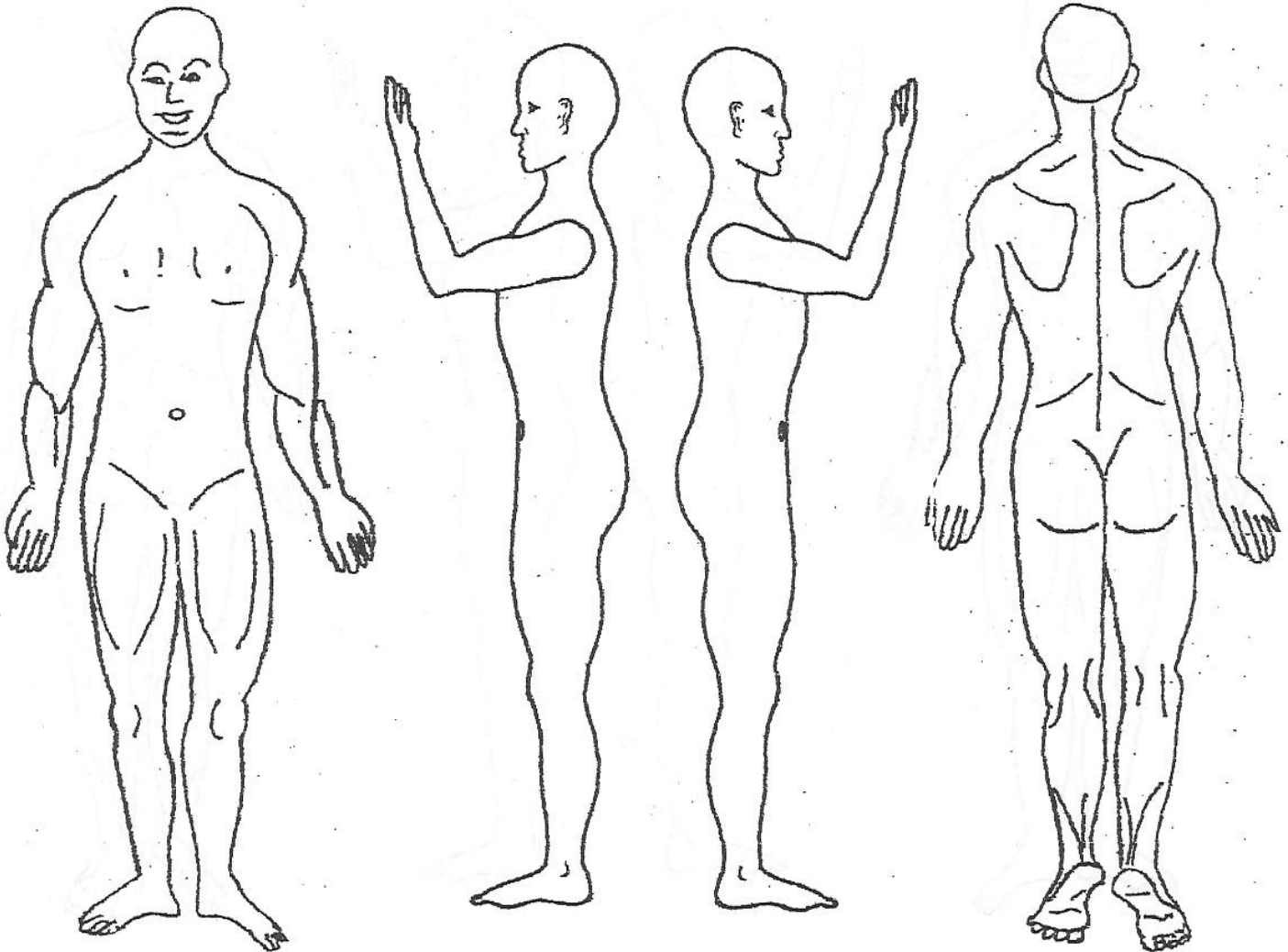
TO THE CLIENT: Please list below the five main health complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all surgeries, operations, traumas, car accidents, injuries you've had *SINCE BIRTH* and label with dates. Please include elective surgeries such as breast implantations, tummy tuck, face-lift, burned off moles, etc. *Don't Forget C-sections, Vaccination scars, episiotomies, earring punctures, tattoos, facelift scars, previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.*

- | | | | |
|----------|-------------|----------|-------------|
| A. _____ | Date: _____ | B. _____ | Date: _____ |
| C. _____ | Date: _____ | D. _____ | Date: _____ |
| E. _____ | Date: _____ | F. _____ | Date: _____ |
| G. _____ | Date: _____ | H. _____ | Date: _____ |
| I. _____ | Date: _____ | J. _____ | Date: _____ |
| K. _____ | Date: _____ | L. _____ | Date: _____ |
| M. _____ | Date: _____ | N. _____ | Date: _____ |

FOR THE FIGURE BELOW: Indicate the location of your traumas with the corresponding letter (A-L) from the list above. Please draw a *line* for any scar, an *X* for any trauma and a *circle* for any internal metal objects such as a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.



**PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF
NUTRITION RESPONSE TESTING™**

PLEASE READ BEFORE SIGNING:

I specifically authorize Monica Hershaft to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

I acknowledge that MONICA HERSHAFT is not a medical doctor and is not licensed in the state of California. I understand that MONICA HERSHAFT is trained in Nutrition Response Testing through Ulan Nutritional Systems and as a Nutritional Consultant through GCNM and provides nutritional and other health related information to help me attain and maintain my best health. MONICA HERSHAFT will help determine which nutrients my body needs bolstered. All recommendations are designed to help me keep and enjoy my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that MONICA HERSHAFT does NOT diagnose, treat, cure or claim to cure cancer or any other disease, physical or mental. I request that MONICA HERSHAFT perform an evaluation and set up a program for me for the purpose of enhancing my health and well being. I understand that this program is not intended as a substitute for regular medical care.

I understand that for the first 2-3 months of treatment, generally weekly visits are recommended to allow for proper updates to the program as the body goes through changes as the health improves. I understand that I also need to follow the dietary recommendations of the program in order to achieve optimal results. I understand that I should not take additional vitamins/herbs/supplements/over the counter medications without informing Monica and bringing them in for interaction testing. I understand that taking any additional vitamins/herbs/supplements/over the counter medications can affect the outcome of my program and the results. If any problems or concerns come up that concern my program, I will communicate those thoughts to Monica so that they can be addressed.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State ____ Zip _____

Phone: (____) _____ - _____

Signed: _____

ASYRA CONSENT FORM

The information presented on the Asyra is for informational purposes ONLY. It is not intended to replace medical advice and/or care. You should not use the information contained herein for diagnosing or treating a health problem or disease, or prescribing any medication.

Monica Hershaft is not a licensed medical or naturopathic doctor. She does not offer medical diagnoses, cure, advice, or treatment for any particular medical disease ailment, injury, infirmity, deformity, pain, or other physical or mental condition. She does not prescribe or recommend discontinuance of any prescription drugs. Rather, her program focuses on building health through energy field and nutritional balancing, and life style changes.

Computerized Electrodermal Testing, as featured at MLH Wellness, is used by tens of thousands of medical and other health practitioners around the world. Though there are many published studies indicating it's efficacy, it is generally not recognized by conventional medicine or the Food and Drug Administration. However Computerized Electrodermal Testing instruments are duly registered as Class II devices with the FDA. No licensure is required to do Electrodermal Testing

Consult with your licensed physician or naturopath before taking any action. Every effort has been made to insure that all information is correct, but we can not be responsible for errors - typographical or otherwise.

Terms

This service is open only to residents of those jurisdictions where participation is legal and not prohibited. The client acknowledges that it is his/her sole responsibility to understand the laws in his/her jurisdiction, which may prohibit use of this service. You must understand and accept that we are unable to provide you any legal advice or assurances.

NAME _____

SIGNATURE _____

DATE _____

MLH Wellness (310) 425-3045 www.MLHWellness.com

I acknowledge that I will be charged \$60 for any missed visits that I don't give 24 hours notice for including "no-shows".

This does not include Sundays or after hours. You must contact during normal business hours and give notice during normal business hours.

I authorize my credit card on file to be charged \$60 for any missed visits that I did not give 24 hours notice for.

I understand that it is advised that I cancel or reschedule by speaking to someone directly. I also may cancel via email or voicemail; but, it is not considered canceled or rescheduled unless I receive confirmation email or phone call in return and can be subject to charge if I don't receive a confirmed acknowledgment of my cancellation.

name _____

date _____ print name _____

Introduction to Nutrition Response Testing

What is Nutrition Response Testing?

Nutrition Response Testing is a non-invasive system of analyzing the body in order to determine the underlying causes of ill health. When these are corrected through safe, natural, nutritional means, the body can repair itself in order to attain and maintain more optimum health.

First the Analysis

The analysis is done through testing the body's own neurological reflexes and certain acupuncture points.

Nutrition Response Testing analyzes the different points on the surface of the body that relate to each and every organ and function of the body.

By testing the Nutrition Response Testing reflexes, we identify exactly what the body needs and how to meet that need to restore balance and remove whatever stressors are interfering with the body's normal function.

How Do We Do The Analysis?

In Nutrition Response Testing, we contact these reflex areas with our own hand. With the other hand, we will test the muscle of your extended arm. If the reflex being contacted is "active" the nervous system will respond by reducing energy to the extended arm, and the arm will weaken and drop. This drop signifies underlying stress or dysfunction, which can be affecting your health.

The "Personalized Health Program"

Our next step is to test specific nutritional formulas against those weak areas, to find which ones bring the reflexes back to strength.

By following the program precisely, you are on your way to restoring normal function. It's that simple!

What is Designed Clinical Nutrition?

We use **Designed Clinical Nutrition** to eliminate the cause of the problem, so that the body can correct itself.

It is concentrated whole food in a tablet, capsule, or tea prepared using a process that preserves all of the active enzymes and vital components that make it work as Nature intended. These real food supplements have been designed to specifically match the needs of the body.

Designed Clinical Nutrition is NOT 'over-the-counter' vitamins. Over-the-counter vitamins are pharmaceutically produced in a laboratory. They are not derived from whole foods and often make you even more deficient and nutritionally out-of-balance. They can create health problems.

The Technology Behind What We Do

Having been designed through decades of clinical use on tens of thousands of clients, you can be assured that Nutrition Response Testing is capable of evaluating and addressing your health concerns.

A complete Nutrition Response TestingSM analysis can be done on each subsequent visit. Often these reveal additional layers of dysfunction. These can then be addressed **in the correct sequence for your body**.

Each client gets a completely individualized program for your unique body.

Therefore, since every case is different, by following the correct sequence as revealed through Nutrition Response Testing, even the most complicated cases can be handled.

Is it Possible to Restore Health?

The deficiencies or imbalances accumulated over the years can lead to a breakdown in resistance, or immunity resulting in health challenges. The **good news** is that it is possible to reverse the process!

Each cell, tissue, and organ in your body is in the process of replacing itself every day. Designed Clinical Nutrition provides exactly what the body needs to repair, replace, & restore. Nutrition Response Testing tells you when and what to use to bring about the desired result.

But, in the end, you are the one responsible for your own condition. Symptoms are your body's way of telling you something needs addressing and correcting. Ignoring it won't make it go away; it will just develop into more symptoms or possibly something more serious if left untreated. Don't wait until that happens.

Treat the source...not the symptom.

May you never be the same!

Sincerely,
Monica Hershaft

www.MLHWellness.com (310) 425-3045