



Medical Intake and HCG Program Enrollment Form

Welcome to your transformation!

PureRealms is ready to assist you on your journey to radiant health.

We understand that patience is necessary to fill out these forms and hope you will persevere as your health is most important to both PureRealms and you. These forms are legally required.

Relax, smile, and enjoy the time taken to assure that any medical issues are understood by PureRealms as completely as possible in order to create the finest in personal service excellence.

You are worth it! Your privacy and rights are honored.

**Please complete the following questionnaire as best you can.
Then FAX the entire form to 970-453-8959. Thank You and Let's Begin!**

Name _____

Age _____ Male / Female _____ Date of Birth ____/____/____

Height _____ Weight _____ Marital Status _____

Referred By _____

E-mail _____

Telephone (H) (_____) _____ - _____ Cell (_____) _____ - _____

Address _____

City _____ State _____ Zip _____

Emergency Information *(Please indicate who to notify in case of emergency)*

Name _____ Relationship _____

Tel (Home) (_____) _____ - _____ Work (_____) _____ - _____

Cell (_____) _____ - _____



Chief Complaint(s) Please indicate your medical issues and how long you've had them:

What kinds of treatments have you received and/or currently receiving?

List any Hospitalizations & Surgeries (include date and place)

List medications being taken (include dosage)

Family History (please include the details)

- Migraines, Stroke, Heart Disease, High Blood Pressure, Mental Illness, Allergies, Asthma, Gall Stones, Arthritis, Cancer, Diabetes, Thyroid, Glaucoma, Epilepsy

Are you allergic to any of the following? If yes, please specify

- Medicine, Food, Herbs, Others

Do you have or are you any of the following?

- Pacemaker, Electric Implants, Metal Implants, Severe Bleeding Disorders, Pregnant, HIV Positive, Hepatitis A/B/C

Life style:

- Exercise, Sedentary, Eat 3 meals every day, Eat at regular time every day, Tea, Coffee, Soft drinks, Alcohol, Cigarettes, Drugs

What are your daily typical meals?

Breakfast:

Lunch:

Dinner:



Additional information:

Please check if you have had (in the past three months):

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Strong Thirst (hot or cold drinks) | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Tetanus Shot |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Poor Sleep Habits | <input type="checkbox"/> Frequent cold/flu |

Skin and Hair

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Open sore | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Acne | <input type="checkbox"/> Loss of Hair |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Corns | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Warts | <input type="checkbox"/> Nail Problems |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Eczema | | |

Head, Eyes, Ears, Nose and Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Facial Pain |
| <input type="checkbox"/> Headaches | | |

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Coronary Heart Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Pneumatic Heart Disease | <input type="checkbox"/> Difficulty in Breathing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hardening of Arteries |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Mitral Stenosis | <input type="checkbox"/> Swelling of Hands/Feet | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Mitral Prolapse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands/feet |

Respiratory

- | | | |
|--|---|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain w/ deep breath |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of Phlegm |
| <input type="checkbox"/> Difficulty breathing lying down | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| | <input type="checkbox"/> Pleurisy | |

Gastrointestinal

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Colitis | |



Genitourinary

- Bed Wetting
- Kidney Infections / Stones
- Genital Herpes
- Cystitis
- Blood in Urine
- Painful Urination
- Venereal Disease
- Incontinence
- Frequent Urination
- Bladder Infections
- Prostate Problems

Pregnancy and Gynecology

- Age at 1st Menstruation
- Breast Lumps
- Use of Birth Control
- Hot Flash/Night Sweats
- Unusual Character (heavy/light)
- Vaginal Sores
- Irregular Periods
- Frequent changes in emotion
- Vaginal Discharge
- Uterine Fibroids
- Osteoporosis

Number of Pregnancies ___ Number of Abortions ___ Number of Births ___

Number of Miscarriages ___ Time between Menstruation _____

Duration of Menstruation _____ Date of Last Menstruation _____

Fertility Information

of IVF procedures _____ # of IUI

Procedures _____

Has a physician diagnosed a difficulty with fertility due to:

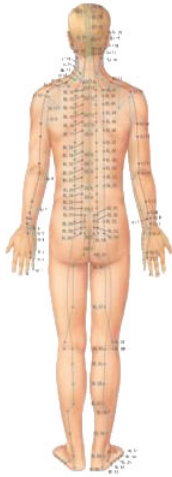
- Female Factor?
- Male Factor?
- Unexplained

Musculoskeletal

- Neck Pain
- Back Pain
- Hand/Wrist Pain
- Muscle Pains
- Muscle Weakness
- Shoulder Pain
- Knee Pain
- Foot/Ankle Pain
- Hip Pain



Please indicate on the figures below the areas of the body you experience your pain:
 dull/achy sharp/stabbing burning tingling numbness electrical



Neuropsychological

- Seizures
- Areas of Numbness
- Concussion
- Bad Temper
- Difficulty Concentrating

- Dizziness
- Lack of Coordination
- Depression
- Easily susceptible to stress

- Loss of Balance
- Poor Memory
- Anxiety
- ADD

Infection

- Measles
- Rheumatic Fever
- Malaria
- Small Pox

- Mumps
- Tuberculosis
- Chicken Pox
- Other _____

- Whooping Cough
- Typhoid Fever
- Scarlet Fever

WEIGHT QUESTIONS

Why do you want to lose weight? _____

What is your ideal weight? _____

Are you ready to undergo a weight loss program? _____

Do you have any difficult issues surrounding your weight loss program such as family support, lack of motivation, incapacitation, or other circumstance?

What have you tried so far for weight loss management?

When is the best date for you to start the program? _____



Do you have any upcoming events such as vacations, anniversaries, birthdays, etc. that may make this difficult for the 23 or 42 day program?

Are you receiving psychological therapy? _____

Are you currently using or experiencing any of the following?

- Hormone replacement therapy
- Anti-depressant therapies or prescriptive drugs for depression
- Fibroids
- Pregnant, possibly pregnant, nursing
- Gout
- Diabetes
- Gall bladder issues

COMMITMENTS TO EACH OTHER

From PureRealms to You:

PureRealms will provide experience and guidance to assist you throughout your program. We will be there for twice weekly emails or phone calls. You may desire additional support, in which case we will discuss this with you and reach agreement with you. The charge for additional support will be at the rate \$15 for 15 minutes.

Your Responsibilities:

To be successful as a program participant, it is expected that you will maintain the recommended dietary protocols and HCG injection schedule. You are also expected to tell PureRealms immediately of any difficulties, traumas, upsets and other influencing factors which may inhibit your successful and healthy weight loss.

LEGAL STATEMENTS

The products and the claims made about specific products on or through this site have not been evaluated by the United States Food and Drug Administration (FDA) and are not approved to diagnose, treat, cure or prevent disease. Although there are thousands of testimonials regarding weight loss with HCG, the FDA's position is that "hCG should never be used in the treatment of obesity" and "hcg has not been demonstrated to be effective adjunctive therapy in the treatment of obesity". The information provided on this site is for informational purposes only and is not intended as a substitute for advice from your physician or other health care professional or any information contained on or in any product label or packaging.

You should not use the information on our website for diagnosis or treatment of any health problem or for prescription of any medication or other treatment. You should consult with a healthcare professional before starting any diet, exercise or supplementation program, before



taking any medication, or if you have or suspect you might have a health problem. In particular, please consult with your healthcare provider if you are pregnant, nursing, chronically ill, elderly, under 18, diabetic or taking medications.

This HCG protocol is intended only to assist users in their personal weight loss efforts. This is not written by an American Medical Association (AMA) organization and offers no Western medical advice or diagnosis. Nothing contained in the program should be construed as medical advice or diagnosis. The information generated should not be interpreted as a substitute for AMA physician consultation evaluation, or treatment.

In Traditional Chinese Medicine, HCG is viewed as a Kidney Yin and Yang tonic and as a Jing tonic which works successfully on the brain (where the hypothalamus is located) and the kidneys to restore metabolism.

You are urged and advised to seek the advice of a physician or attending alternative licensed practitioner before beginning any weight loss effort or regimen. The information given in the program is not meant to replace their advice regarding your own specific situation.

We strongly recommend you read Dr. A.T.W. Simeone's manuscript *Pounds and Inches*, Kevin Trudeau's book *The Weight Loss Cure They Don't Want You to Know About*, and Linda Prinster's *The HCG Weight Loss Diet Cure*. Any information included should never be construed as medical advice.

Counter indications for the program include: gall bladder issues, gout, brittle/unstable diabetes, fibroids, anti-depressant use and hormone replacement therapy. Please contact you primary health care provider if these are concerns.

I do not have any of the above conditions in the previous paragraph.

I have read and understand the above paragraphs and agree to follow them on the HCG program.

Signature

Date

Great! You did it!

Now send this entire form to PureRealms so we can begin!

Fax: 970-453-8959