

Client's Name: _____

Andromeda Assessment and Wellness Plan Data Collection Form

Allocca Biotechnology, LLC

Fax (888) 878-4199

Practitioner's Name: _____

Pre-Test Instructions

1. No alcohol consumption within 24 hours prior to the test.
2. No exercise, caffeine, or food within 4 hours prior to the test.
3. Drink 2 glasses of water 2 hours before the test.
4. Wear a short sleeved shirt and pants that can be rolled up.

This section to be completed by Patient

Client's Full Name: _____ Date: _____

Street Address: _____ City _____ State _____ Zip _____

Phone () _____ Email: _____

Sex: Male Female Transgender male to female Transgender female to male.

Age: _____

Occupation _____ Referred by _____

Medications _____

Number of Bowel Movements per Week _____

Required Tests/Information (Urinalysis and Symptoms are also required):

Height (feet, inches): _____

Weight (pounds): _____ (do not enter here if you are using the BIA scale on page 2)

Blood Pressure: Systolic _____ Diastolic _____

Daytime Ear Core Temperature (97.8° - 99.6°F) (36.6° - 37.6° C): _____

Optional Tests:

Zinc Taste Test: No Taste Taste

Pulse Oximetry, PSO2: _____ HR _____

Comments _____

Client's Name: _____

Blood Glucose

Blood Glucose (mg/dl) _____

Bioelectric Impedance Analysis

Weight (pounds) _____

Fat Mass - percent _____

Skeletal Muscle Mass - percent _____

Visceral Fat Mass - percent _____

Other Tests

- Diabetic Type 1 or Type 2
- Dysbiosis Test Positive
- Bacterial Test Positive
- Yeast/Fungal Test Positive
- Oxidation Test Positive
- Roundworms Test Positive
- High L-Forms Test Positive
- Weak Immune Function Test Positive
- Low Iron Test Positive
- Low B12/Folic Acid Test Positive
- Poor Kidney Function Test

Basal Metabolic Test:

(women: average of days 2 and 3, men: average 5 days) (degrees F) _____ (degrees C) _____

BrainicityTM _____

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Lower Extremity Physiologic Study, Single Level (Ankle Brachial Index Assessment Form)

- | | |
|--|--|
| <input type="checkbox"/> Risk Factors | <input type="checkbox"/> Age over 50 |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperlipemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Previous Vascular Surgery |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Family History Heart |

- Current Symptoms**
- Intermittent Claudication
 - Numbness, tingling in feet
 - Ulcerations
 - Other:

ABI / Severity of Disease
 > 1.40 = Noncompressible
 1.00 - 1.40 = Normal
 0.91 - 0.99 = Borderline
 0.00 - 0.90 = Abnormal
 2011 ACCF/AHA Guidelines

ICD: _____

Right Arm
 Systolic Pressure _____ mmHg

Left Arm
 Systolic Pressure _____ mmHg

Right ABI at Posterior Tibial
 Right PT Pressure _____ = _____ = _____
 Higher Arm Pressure _____

Left ABI at Posterior Tibial
 Right PT Pressure _____ = _____ = _____
 Higher Arm Pressure _____

Right Posterior Tibial
 Systolic Pressure _____ mmHg
 Triphasic (Normal)
 Biphasic (Diminished)
 Monophasic (Poor)

Left Posterior Tibial
 Systolic Pressure _____ mmHg
 Triphasic (Normal)
 Biphasic (Diminished)
 Monophasic (Poor)

Right ABI at Dorsalis Pedis
 Right DP Pressure _____ = _____ = _____
 Higher Arm Pressure _____

Right Dorsalis Pedis
 Systolic Pressure _____ mmHg
 Triphasic (Normal)
 Biphasic (Diminished)
 Monophasic (Poor)

Left Dorsalis Pedis
 Systolic Pressure _____ mmHg
 Triphasic (Normal)
 Biphasic (Diminished)
 Monophasic (Poor)

Left ABI at Dorsalis Pedis
 Right DP Pressure _____ = _____ = _____
 Higher Arm Pressure _____

- Right**
- PT
 - DP

- Left**
- PT
 - DP

Client's Name: _____

Urinalysis - Fresh Collection

Reference: Bayer Multistix 10 SG urine reagent strips

Appearance:

- Cloudy (Infection or too alkaline)
- Clear (Normal)

Color:

- Colorless (High water intake or anemia or bile deficiency)
- Yellow (Normal)
- Dark Yellow (Dehydration or antibiotics or Vitamin A, B supplements or fasting & high fever)
- Yellow-brown or Yellow-green (Bile pigments present or drugs)
- Red or Red-brown (Eating beets or hemoglobin present or medications)
- Orange-red or Orange-brown (Urobilinogen present or drugs)
- Dark-brown or Black (Malanins or tumors or iron/hemoglobin present)

Glucose (Positive indicates diabetes) mg/dl

- Negative
- 100
- 250
- 500
- 1000
- 2000 or more

Bilirubin (Positive indicates liver dysfunction or biliary obstruction)

- Negative
- +
- ++
- +++

Ketones (Positive indicates fasting or carbohydrate starvation or vomiting or diabetes or diarrhea or diabetes or excessive alcohol use) mg/dl

- Negative
- 5
- 15
- 40
- 80
- 160

Specific Gravity (Above 1.022 indicates renal dysfunction or dehydration)

- 1.000
- 1.005
- 1.010
- 1.015
- 1.020
- 1.025
- 1.030

Blood (Positive indicates menstruation or infection or strenuous exercise or renal dysfunction or exposure to excessive cold or drugs. Follow up with microscopic exam)

- Negative
- Trace
- Moderate
- Hemolyzed
- +
- ++
- +++

pH (Above 7 indicates metabolic alkalosis or infection or high alkaline ash diet. Below 5 indicates metabolic acidosis or high stress or excessive stimulants (caffeine, alcohol, drugs))

- 5.0
- 6.0
- 6.5
- 7.0
- 7.5
- 8.0
- 8.5

Protein (Above trace indicates renal dysfunction or excess protein in diet or strenuous exercise or emotional stress or high fever or exposure excessive to heat or cold) mg/dl

- Negative
- Trace
- 30
- 100
- 300
- 2000 or more

Urobilinogen (Above 1 indicates hemolytic anemia or pernicious anemia or sickle cell anemia) mg/dl

- 0.2
- 1
- 2
- 4
- 8

Nitrite (Positive indicates bacterial infection)

- Negative
- Positive

Leukocytes (Positive indicates infection or high Vitamin C intake)

- Negative
- Trace
- +
- ++
- +++

Reference: Bayer Multistix 10 SG urine reagent strips

Check all symptoms below that repeat regularly (daily, weekly, monthly)

Daily Exercise Level:

- Little to no exercise
- Light exercise (1–3 days per week)
- Moderate exercise (3–5 days per week)
- Heavy exercise (6–7 days per week)
- Very heavy exercise (twice per day, extra heavy workouts)

Symptoms that Repeat:

- 11. Get boils or sty's more than once per year
- 12. Throat infections more than once per year (sore throat)
- 13. Cold sores, fever blisters more than once per year
- 14. Any infection with fever more than once per year
- 15. Swollen lymph glands more than once per year
- 16. Ear infections more than once per year
- 17. Slow to recover from cold or flu
- 18. Catch colds or flu easily
- 19. Lacerations (cuts become infected easily)
- 20. Itchy nose
- 21. Itchy eyes
- 22. Itchy roof of mouth or throat
- 23. Clear watery nasal discharge
- 24. Headaches
- 25. Mucous in the throat
- 26. Post nasal drip
- 27. Discharge from the eyes
- 28. Puffiness under the eyes
- 29. Ear discharge or stuffed up
- 30. Nasal congestion
- 31. Running nose
- 32. Wheezing
- 33. Sneezing
- 34. Fatigue
- 35. Exposed to cigarette smoke
- 36. Exposed to mold
- 37. Sinus congestion
- 38. Food allergies or sensitivities
- 39. Skin rashes
- 40. Entire body aches, painful to touch
- 41. Swollen joints
- 42. Certain foods make you sick, nauseous, depressed, jittery
- 43. Painful stomach or intestine
- 44. Alternating constipation and diarrhea
- 45. Swollen or itchy tongue or mouth
- 46. Difficulty in swallowing
- 47. Hyperactivity
- 48. Fatigue increases after eating
- 49. Exposed to chemicals or radiation at work
- 50. Eat luncheon meats containing nitrates or nitrites
- 51. Eat fruits and vegetables that contain pesticides
- 52. Eat foods that contain monosodium glutamate (MSG)
- 53. Use artificial sweeteners regularly
- 54. Milk makes allergy symptoms worse
- 55. Pain in chest and left arm
- 56. Calf muscles cramp while walking
- 57. Heart palpitations
- 58. Feel jittery
- 59. Irregular heart beats
- 60. Swelling of feet and ankles
- 61. Fast heart beat
- 62. Exhaust with minor exertion
- 63. Light-headedness
- 64. General weakness
- 65. Smoke cigarettes/tobacco

Client's Name: _____

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|---|--|--|
| <input type="checkbox"/> 66. Chew tobacco | <input type="checkbox"/> 90. Bleeding gums or periodontal disease | <input type="checkbox"/> 112. Foul smelling stool |
| <input type="checkbox"/> 67. More than 3 cups of coffee daily | <input type="checkbox"/> 91. Stomach pains after meals | <input type="checkbox"/> 113. Dry skin or dry hair |
| <input type="checkbox"/> 68. High daily stress level | <input type="checkbox"/> 92. Nausea | <input type="checkbox"/> 114. Pain in left side of rib cage |
| <input type="checkbox"/> 69. Cold hands and feet | <input type="checkbox"/> 93. Dependency on antacids | <input type="checkbox"/> 115. Acne |
| <input type="checkbox"/> 70. Tingling or burning in hands and feet | <input type="checkbox"/> 94. Butterfly sensations in stomach | <input type="checkbox"/> 116. Difficulty gaining weight |
| <input type="checkbox"/> 71. Numbness in extremities | <input type="checkbox"/> 95. Difficulty in belching | <input type="checkbox"/> 117. Dizziness when standing suddenly |
| <input type="checkbox"/> 72. Skin sores of the legs or feet | <input type="checkbox"/> 96. Stomach pain when emotionally upset | <input type="checkbox"/> 118. Loss of vision when standing suddenly |
| <input type="checkbox"/> 73. Spider veins on nose or face | <input type="checkbox"/> 97. Sudden, acute indigestion | <input type="checkbox"/> 119. Crave sweets |
| <input type="checkbox"/> 74. Ringing in ears | <input type="checkbox"/> 98. Relief of stomach pain by drinking carbonated beverages | <input type="checkbox"/> 120. Crave carbohydrates |
| <input type="checkbox"/> 75. Poor concentration | <input type="checkbox"/> 99. Relief of stomach pain by drinking cream or milk | <input type="checkbox"/> 121. Headaches relieved by eating sweets or alcohol |
| <input type="checkbox"/> 76. Slurred speech | <input type="checkbox"/> 100. History of ulcer or gastritis | <input type="checkbox"/> 122. Impatient |
| <input type="checkbox"/> 77. Salt foods without tasting | <input type="checkbox"/> 101. Current ulcer or gastritis | <input type="checkbox"/> 123. Moody |
| <input type="checkbox"/> 78. Exercise regularly with low to moderate exertion | <input type="checkbox"/> 102. Black stool while not taking iron supplements | <input type="checkbox"/> 124. Irritable if a meal is missed |
| <input type="checkbox"/> 79. Exercise regularly with high exertion (Aerobics) | <input type="checkbox"/> 103. Nervousness | <input type="checkbox"/> 125. Wake up in middle of the night craving sweets |
| <input type="checkbox"/> 80. Vascular surgery | <input type="checkbox"/> 104. White spots or lines on finger nails | <input type="checkbox"/> 126. Poor memory |
| <input type="checkbox"/> 81. Chest pain without left arm pain | <input type="checkbox"/> 105. Indigestion 1-3 hours after eating | <input type="checkbox"/> 127. Feel faint |
| <input type="checkbox"/> 82. Tightness or pressure in the chest | <input type="checkbox"/> 106. Diarrhea | <input type="checkbox"/> 128. Calmer after eating |
| <input type="checkbox"/> 83. Upper chest or neck itch | <input type="checkbox"/> 107. Roughage and fiber causes constipation | <input type="checkbox"/> 129. Frequent urination |
| <input type="checkbox"/> 84. Chronic cough | <input type="checkbox"/> 108. Mucous in the stools | <input type="checkbox"/> 130. Night sweats |
| <input type="checkbox"/> 85. Difficulty in breathing | <input type="checkbox"/> 109. Stool poorly formed | <input type="checkbox"/> 131. Increased thirst |
| <input type="checkbox"/> 86. Shortness of breath | <input type="checkbox"/> 110. Shiny stool | <input type="checkbox"/> 132. Lowered resistance to wound infection |
| <input type="checkbox"/> 87. Sensitive to smog / air pollution | <input type="checkbox"/> 111. Three or more large bowel movements daily | <input type="checkbox"/> 133. Leg sores |
| <input type="checkbox"/> 88. Infections settle in lungs | | <input type="checkbox"/> 134. Poor wound healing |
| <input type="checkbox"/> 89. Respiratory attacks that last hours to days | | <input type="checkbox"/> 135. Feel energized from exercise |
| | | <input type="checkbox"/> 136. Failing eyesight |

Client's Name: _____

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|---|--|--|
| <input type="checkbox"/> 137. Crave sweets, but eating sweets does not relieve symptoms | <input type="checkbox"/> 159. Abdominal pain is triggered by eating | <input type="checkbox"/> 183. Don't use vitamins and minerals regularly |
| <input type="checkbox"/> 138. Family history of diabetes | <input type="checkbox"/> 160. Yellowish conjunctiva (white part of the eyes) | <input type="checkbox"/> 184. Use very large-doses of vitamins and/or minerals regularly |
| <input type="checkbox"/> 139. Glucose (sugar in urine) | <input type="checkbox"/> 161. Pain radiates along outside of leg | <input type="checkbox"/> 185. Neurological disorders |
| <input type="checkbox"/> 140. Elevated blood glucose (sugar) | <input type="checkbox"/> 162. Intolerance to greasy foods | <input type="checkbox"/> 186. Sore or burning tongue |
| <input type="checkbox"/> 141. Toe and fingernail fungus | <input type="checkbox"/> 163. Headaches after eating | <input type="checkbox"/> 187. Lower back pains |
| <input type="checkbox"/> 142. History of antibiotic use | <input type="checkbox"/> 164. Dark urine | <input type="checkbox"/> 188. Poor night vision |
| <input type="checkbox"/> 143. Anemic or recent history of anemia | <input type="checkbox"/> 165. Light colored stool | <input type="checkbox"/> 189. Confusion |
| <input type="checkbox"/> 144. Itchy skin | <input type="checkbox"/> 166. Hard stool | <input type="checkbox"/> 190. Sore or sensitive gums |
| <input type="checkbox"/> 145. Itchy between toes and fingers | <input type="checkbox"/> 167. Gray colored skin | <input type="checkbox"/> 191. Leg pain or cramps |
| <input type="checkbox"/> 146. Abdominal bloating | <input type="checkbox"/> 168. Pain in right side under rib cage | <input type="checkbox"/> 192. Pain in feet |
| <input type="checkbox"/> 147. Intestinal gas | <input type="checkbox"/> 169. Big toe painful | <input type="checkbox"/> 193. Some alcohol use regularly |
| <input type="checkbox"/> 148. Chemical sensitivities | <input type="checkbox"/> 170. Don't eat regular balanced meals | <input type="checkbox"/> 194. High stress levels effect stomach |
| <input type="checkbox"/> 149. Depression | <input type="checkbox"/> 171. Don't get enough to eat | <input type="checkbox"/> 195. Lack of appetite |
| <input type="checkbox"/> 150. Crave sweets and yeast containing foods | <input type="checkbox"/> 172. More than 10 beers/ week | <input type="checkbox"/> 196. Dizziness |
| <input type="checkbox"/> 151. Bladder and kidney infections | <input type="checkbox"/> 173. More than 10 ounces of alcohol/week | <input type="checkbox"/> 197. Inflamed corners of the mouth |
| <input type="checkbox"/> 152. Dark colored stool | <input type="checkbox"/> 174. Eat candy regularly | <input type="checkbox"/> 198. Steeply curved nails |
| <input type="checkbox"/> 153. Do not eat high fiber foods daily | <input type="checkbox"/> 175. Drink soda pop regularly | <input type="checkbox"/> 199. Exposed to lead in the air or water |
| <input type="checkbox"/> 154. Less than 7 bowel movements per week | <input type="checkbox"/> 176. Eat at fast food restaurants regularly | <input type="checkbox"/> 200. Sensitivity to light |
| <input type="checkbox"/> 155. More than 2 bowel movements per day | <input type="checkbox"/> 177. Eat fried foods regularly | <input type="checkbox"/> 201. Sensitive to the cold |
| <input type="checkbox"/> 156. Bowel movements are irregular | <input type="checkbox"/> 178. Use refined sugars regularly | <input type="checkbox"/> 202. Weight gain |
| <input type="checkbox"/> 157. Abdominal pain on right or left side | <input type="checkbox"/> 179. Diet often | <input type="checkbox"/> 203. Change in personality |
| <input type="checkbox"/> 158. Abdominal pain relieved by a bowel movement | <input type="checkbox"/> 180. Hair loss | <input type="checkbox"/> 204. Loss of temper or irritable |
| | <input type="checkbox"/> 181. Dry skin | <input type="checkbox"/> 205. Enlarged neck |
| | <input type="checkbox"/> 182. Bones protrude | <input type="checkbox"/> 206. Trouble waking up in the morning |

Client's Name: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> 207. Low sex drive | <input type="checkbox"/> 229. Joints lock with movement | <input type="checkbox"/> 247. Nausea associated with headache |
| <input type="checkbox"/> 208. Swollen (bulging eyes) | <input type="checkbox"/> 230. Early afternoon sleepiness | <input type="checkbox"/> 248. Sensitive to light, especially during headache |
| <input type="checkbox"/> 209. Warm, moist skin | <input type="checkbox"/> 231. Skin nodules | <input type="checkbox"/> 249. Sensitive to noise, especially during headache |
| <input type="checkbox"/> 210. Tremors | <input type="checkbox"/> 232. Deep aching pain in bones, particularly the back | <input type="checkbox"/> 250. Extremities are cold before and during headache |
| <input type="checkbox"/> 211. Increased activity | <input type="checkbox"/> 233. Pain increases when weight is applied | <input type="checkbox"/> 251. Family history of migraine |
| <input type="checkbox"/> 212. Increased appetite | <input type="checkbox"/> 234. Vertebrae crush fractures | <input type="checkbox"/> 252. Difficulty with speech before headache |
| <input type="checkbox"/> 213. Weight loss | <input type="checkbox"/> 235. Bone fractures | <input type="checkbox"/> 253. Intensity of headache increases when lying down |
| <input type="checkbox"/> 214. Insomnia | <input type="checkbox"/> 236. Bones fracture easily | <input type="checkbox"/> 254. Often prefer seclusion |
| <input type="checkbox"/> 215. Diffuse tanning on exposed and unexposed portions of the body | <input type="checkbox"/> 237. Pain in the extremities | <input type="checkbox"/> 255. Frequent urinary infections |
| <input type="checkbox"/> 216. Black freckles over the forehead, face, neck, and shoulders | <input type="checkbox"/> 238. Burning sensation in the extremities | <input type="checkbox"/> 256. Rarely need to urinate |
| <input type="checkbox"/> 217. Mood swings | <input type="checkbox"/> 239. Weakness in the extremities | <input type="checkbox"/> 257. Urinate when you cough or sneeze |
| <input type="checkbox"/> 218. Dark circles under the eyes | <input type="checkbox"/> 240. Frequent tooth decay | <input type="checkbox"/> 258. Painful or burning urination |
| <input type="checkbox"/> 219. Slender fingers and extremities | <input type="checkbox"/> 242. Throbbing pain on one side or front and rear of head | <input type="checkbox"/> 259. Difficult urination's |
| <input type="checkbox"/> 220. Purple streak or line on the abdomen | <input type="checkbox"/> 243. Headache preceded by a short period of depression, irritability, or restlessness | <input type="checkbox"/> 260. Dripping after urination |
| <input type="checkbox"/> 221. Kidney stones | <input type="checkbox"/> 244. Headache preceded by visual flashing zig-zag lines | <input type="checkbox"/> 261. Cannot hold urine |
| <input type="checkbox"/> 222. Osteoporosis | <input type="checkbox"/> 245. Headache preceded by other visual disturbances | <input type="checkbox"/> 262. Rose colored (bloody) urine |
| <input type="checkbox"/> 223. Emotional disturbances | <input type="checkbox"/> 246. Visual disturbances disappear shortly after headache begins | <input type="checkbox"/> 263. Cloudy urine |
| <input type="checkbox"/> 224. Simultaneous inflammation in multiple joints | | <input type="checkbox"/> 264. Strong smelling urine |
| <input type="checkbox"/> 225. Simultaneous pain in multiple joints | | <input type="checkbox"/> 265. Back or leg pains associated with dripping after urination |
| <input type="checkbox"/> 226. Stiffness lasting more than 30 minutes on arising in mornings | | <input type="checkbox"/> 266. History of kidney or bladder infections |
| <input type="checkbox"/> 227. Stiffness lasting more than 30 minutes after prolonged activity | | |
| <input type="checkbox"/> 228. Deformation of joints | | |

Client's Name: _____

- 267. Back pain in the kidney area
- 268. General water retention
- 312. Drug / Medication addiction
- 313. Must repeat actions constantly
- 314. Making decisions is difficult
- 315. Constant flow of speech
- 316. Obsessed fear of danger
- 317. Previously Diagnosed Diabetic Type 1
- 323 Previously Diagnosed Diabetic Type 2
- 323. Previously Diagnosed Diabetic Type 2
- 321. Previously Diagnosed Migraine
- 322. Previously Diagnosed Hypothyroidism
- 320. Previously Diagnosed with high Cholesterol
- 324. I'm an Athlete

For Males Only:

- 269. A sense of bladder fullness
- 270. Increased straining with smaller and smaller amounts of urine
- 271. Wake up at night to urinate
- 272. Pain or fatigue in the legs or back

- 273. Ejaculation causes pain
- 274. Difficulty attaining and/or maintaining an erection
- 275. Premature ejaculation
- 276. Pain/coldness in genital area
- 277. Infertile
- 278. Varicose veins on scrotum
- 279. Low sperm count
- 280. History of venereal disease

For Females Only:

- 281. Vaginal yeast infections
- 282. History of oral birth control
- 283. Heavy menstrual flow
- 284. Prolonged menstruation
- 285. Short menstruation
- 286. Menstrual irregularities
- 287. Monthly weight gain
- 288. Moodiness and irritability before menstruation
- 289. Change in appetite before menstruation
- 290. Suicidal feeling before menstruation
- 291. Anxiety or anger before menstruation
- 292. Breast fullness and pain before menstruation

- 293. Leg cramps and tenderness before menstruation
- 294. Asthma attacks before menstruation
- 295. Bruise easily before menstruation
- 296. Respiratory allergies worsen before menstruation
- 297. Visual disturbances worsen before menstruation
- 298. Dull ache radiating to low back or legs
- 299. Abdominal pains subsides after several days
- 300. Pelvic soreness
- 301. Have to lie down on first or second days of period
- 302. Clots are expelled during menstruation
- 303. Hot flashes
- 305. Hysterectomy or Menopause
- 306. Heavy bleeding two weeks/month
- 307. Sweating throughout the day
- 308. Dryness of skin, hair, and vagina
- 309. Painful intercourse
- 310. Vaginal pain
- 311. Vaginal itching