ISNS CASE STUDY APPLICATION

RESET

CASE STUDY

Name	First		Middle	Last	
*Date of Birth (DD/MM/YY)			Age		
*E-mail				Gender	Select
If female, currently pregnant?	☐ Yes ☐ No ☐ Unknown				
Height	Select	Weight	Select	BMI	NaN
How did you hear about us?					
Address			*City		
*State/Province			*Zip Code		
*Country			Fax		
Phone Number	Country Code - Phone Number			☐ Mobile ☐ Home ☐ Work	
Alternate Phone Number	Country Code - Phone Number			☐ Mobile ☐ Home ☐ Work	
Race (check all that apply)	☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ Other, specify			Ethnicity	☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown
Does this case have any tribal affiliation?	☐ Yes ☐ No				
Tribes name			Enrolled member?	☐ Yes ☐ No	

PRODUCT INFORMATION

Which product are you currently taking?					
Clean Slate	☐	Start date		How many drops per day?	
Zero In	☐	Start date		How many capsules per day?	
Restore	☐	Start date		How many packets per day?	
ReLive Greens	☐	Start date		How many gm per day?	
Natural Barrier Support	☐	Start date		How many gm per day?	

More details about dosages and experience with the products.

Before the products: In general, would you say your health is

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How long have you been taking the products?

☐ 1 month ☐ 3 month ☐ 6 month ☐ 9 month ☐ 12 month ☐ 24 month

Since you are using the products, what would you say your health is?						
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor						
Have you noticed an increase in libido while taking the Products?				☐ Yes ☐ No		
	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm & peaceful?	☐	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
Have you felt down-hearted and blue?	☐	☐	☐	☐	☐	☐

PRIMARY DIAGNOSIS INFORMATION

*Chief Complaint		*Diagnosis Date	
*Tell us about your symptoms and how you are now.			
*Treatment History			
*Have you had an MRI in the past 12 months?		☐ Yes ☐ No	
*Have you had an X-Ray in the past 12 months?		☐ Yes ☐ No	
*Do you have lab work in the past 12 months to support your results?		☐ Yes ☐ No	

MEDICATIONS INFORMATION

*Do you have any allergies to medications or other substances?	☐ Yes ☐ No
If yes, list medications, vaccinations and/or other substances to which you are allergic	

*Current Medications
*Nutritional Supplements

*Are you taking anticoagulants like Plavix or Coumadin?	☐ Yes	☐ No						
*Have you had any steroid injections like cortisone over the past 3 months?	☐ Yes	☐ No						
If yes, what kind of shots and when did you receive them?								
SOCIAL HISTORY								
*Do you smoke cigarettes?	☐ Yes	☐ No	*Cigars?	☐ Yes	☐ No	*Pipe?	☐ Yes	☐ No
If yes, how much per day?								
*Do you drink beer?	☐ Yes	☐ No	*Wine?	☐ Yes	☐ No	*Liquor?	☐ Yes	☐ No
If yes, how much per day?								

PRIOR SURGERIES
*Please list any prior surgeries and their dates (mm/yyyy). Use “none” if you haven’t had surgery in the past.

CANCER			
*Have you ever been diagnosed with any type of cancer, especially bone marrow cancer?	☐ Yes ☐ No		
If yes, please list type of cancer, month and date of diagnosis and current status			
If you've had a recent mammogram, list the date (mm/yyyy) and result			
If you've had a recent PSA test, list the date (mm/yyyy) and result			
DIABETES			
*Are you diabetic?	☐ Yes ☐ No	If yes, are you taking insulin?	☐ Yes ☐ No
NEUROLOGICAL			
*Vision worsening?	☐ Yes ☐ No	*Black spots in field of vision?	☐ Yes ☐ No
*Uncontrollable eye movements?	☐ Yes ☐ No	*Muscle weakness?	☐ Yes ☐ No
*Muscle wasting?	☐ Yes ☐ No	*Difficulty walking?	☐ Yes ☐ No
*Decreased hand strength?	☐ Yes ☐ No	*Fainting?	☐ Yes ☐ No
*Speech problems?	☐ Yes ☐ No	*Involuntary muscle twitching?	☐ Yes ☐ No
*Depression?	☐ Yes ☐ No	*Dizziness?	☐ Yes ☐ No
*Stiff or rigid muscles that affect walking, movement or speech?			☐ Yes ☐ No
*Overactive or over responsive reflexes?	☐ Yes ☐ No	*Underactive or under responsive reflexes?	☐ Yes ☐ No
*Memory loss?	☐ Yes ☐ No	*Sleep disturbances?	☐ Yes ☐ No
PULMONARY			
*Do you have asthma?	☐ Yes ☐ No	*Chronic bronchitis?	☐ Yes ☐ No
*Chronic cough?	☐ Yes ☐ No	*Emphysema?	☐ Yes ☐ No
*Tuberculosis?	☐ Yes ☐ No		
CARDIOVASCULAR			
*Do you have problems with blood circulation?	☐ Yes ☐ No	*Leg cramps?	☐ Yes ☐ No
*Tired feeling in legs?	☐ Yes ☐ No	*Swollen ankles?	☐ Yes ☐ No
*Varicose Veins?	☐ Yes ☐ No	*Tingling sensation in arms and legs?	☐ Yes ☐ No
*Tingling sensation in hands and legs?	☐ Yes ☐ No	*Do you have any ulcers or open wounds on your body?	☐ Yes ☐ No
*Hypertension or high blood pressure?	☐ Yes ☐ No	*Do you have heart failure?	☐ Yes ☐ No

*Do you have coronary artery disease?	☐ Yes ☐ No	*Have you had a heart attack?	☐ Yes ☐ No
*Have you had a stroke or transient ischemic attack (TIA)?			☐ Yes ☐ No
GASTROINTESTINAL			
*Do you suffer from acid indigestion?	☐ Yes ☐ No	*Do you suffer from bloating?	☐ Yes ☐ No
*Ulcers?	☐ Yes ☐ No	If yes, list type(s) and date(s) diagnosed	
*Recent loss of appetite?	☐ Yes ☐ No	*Recent rapid weight gain?	☐ Yes ☐ No
*Recent rapid weight loss?	☐ Yes ☐ No		
*Have you had upper GI endoscopy?	☐ Yes ☐ No	If yes, when (mm/yyyy)?	
*Do you have hepatitis?	☐ A ☐ B ☐ C	*Gall bladder problems?	☐ Yes ☐ No
*Unusual yellow skin color (jaundice)?	☐ Yes ☐ No	*Recurring Diarrhea?	☐ Yes ☐ No
UPPER RESPIRATORY			
*Chronic Sinusitis?	☐ Yes ☐ No	*Allergic sinus problems?	☐ Yes ☐ No
*Chronic allergic rhinitis?	☐ Yes ☐ No	*Sinus headaches?	☐ Yes ☐ No
*Chronic colds?	☐ Yes ☐ No		
RHEUMATIC SCREEN			
*Do you have rheumatoid arthritis?	☐ Yes ☐ No	*Soft Tissue Rheumatism?	☐ Yes ☐ No
*Joint pain?	☐ Yes ☐ No	*Back pain?	☐ Yes ☐ No
Other rheumatic conditions?			
ENDOCRINOLOGICAL			
*Overactive Thyroid?	☐ Yes ☐ No	*Underactive Thyroid?	☐ Yes ☐ No
*Adrenal gland dysfunction?	☐ Yes ☐ No	*Have you started menopause?	☐ Yes ☐ No
Other endocrinological conditions?			
OTHER ILLNESSES OR CONDITIONS			
*Please list any other illnesses or conditions you have. If you don't have any, enter "None".			

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COVID HISTORY			
Are you currently vaccinated? ☐ Yes ☐ No		If yes, Date #1	
Date #2		Vaccination name	
Have you had Covid? ☐ Yes ☐ No		If yes, were you taking any of the following products?	☐ Clean Slate ☐ ZeroIN ☐ Restore ☐ ReLive Greens ☐ Natural Barrier Support
If yes, are you fully recovered ☐ Yes ☐ No			
If you are not fully recovered please give more detail below			

FAMILY HISTORY			
*Low blood sugar?	☐ Yes ☐ No	*Diabetes?	☐ Yes ☐ No
*Thyroid problem?	☐ Yes ☐ No	*Heart problem?	☐ Yes ☐ No
*Hormone problem?	☐ Yes ☐ No	*Cancer?	☐ Yes ☐ No
*High blood pressure?	☐ Yes ☐ No	*Prostate problem?	☐ Yes ☐ No
*Kidney problem?	☐ Yes ☐ No	*Leukemia?	☐ Yes ☐ No
*Arthritis?	☐ Yes ☐ No	*Mental disorder?	☐ Yes ☐ No
*Anxiety?	☐ Yes ☐ No	*Lung problem?	☐ Yes ☐ No
*Stroke?	☐ Yes ☐ No	*Fatigue?	☐ Yes ☐ No

Please attach lab reports, xrays, imaging, and or health records to support and validate your results.

Click here to upload lab reports, xrays, imaging, and or health records

Submitted Date		**Reviewed By**	