MEMGRAM®
ANALYSIS

Biological Immunity Research Institute
POB 31322
Phoenix, AZ 85046
888-221-4116 • www.biri.org

> *Put your name below. Complete rest if first test or if any of the data has changed since last test.*

Mr.
Mrs.
Miss _____ Sex _____ Race _____
(please print)   Last   First   Full Middle

Address _____ City _____ State _____ Zip _____

Home phone (_____)_____ Your work # (_____)_____ Spouse work # (_____)_____

E-Mail Address: _____

Age _____ Birthdate _____/_____/_____ Height _____' _____" Weight _____ Desired weight _____
                         M   D   Y

Waist measurement (at the navel): _____ Hip measurement (females): _____ Wrist measurement (males): _____

Usual rising time: _____ Usual bedtime: _____ Usual mealtimes — Breakfast: _____ Lunch: _____ Dinner: _____

Frame size (circle one): small   medium   large   Marital status: M S D W   # of children _____ Age of youngest _____

Occupation _____ Employer _____ Spouse Name _____ Sp. Employer _____

Is your exercise routine: Strenuous (_____)   Moderate (_____)   Light (_____)   Sedentary (_____)

Do you smoke? _____ How much? _____ How many years? _____

If you've quit, how many years did you smoke? _____ How much? _____ When quit? _____

Take prescription or non-prescription drugs? _____ For what? _____ How many months? _____

If you've quit, how many months did you take them? _____ When quit? _____

Any major surgeries? What and when? _____

What have you been medically diagnosed as having? _____

Primary reason you came to us for analysis? _____

Closest Relative Name/Address _____ Phone (_____)_____

Your doctor's name: _____

Address _____ City _____ State _____ Zip _____

Doctor's Phone #: (_____)_____ Type of Practitioner: _____

BIEBCA-011308

MEMGRAM® M-CRISIS QUESTIONNAIRE

Rate each statement 0-5 according to the intensity of how you have recently felt.

0=Never 1=Rarely 2=Occasionally 3=Regularly 4=Often 5=Very Often

Have you recently had:

_____ 1. infections or inflammations, pus or mucus formations?

_____ 2. blood pressure issues, strong pulse, blood clots or chest constriction?

_____ 3. bowel dysfunction such as diarrhea or constipation?

_____ 4. digestive problems, such as indigestion, gas, heartburn or acid reflux?

_____ 5. the flu, viral disease, or sinus problems?

_____ 6. tired after eating, felt constant hunger or felt irritated?

_____ 7. a cough, hoarseness or wheezing (asthmatic) problems?

_____ 8. issues with sexual performance, flushes of heat or physical weakness?

_____ 9. chronic low back soreness, stiff shoulders or neck, especially with temperature change?

_____ 10. vertigo, dizziness or a tendency toward fearfulness or anxiety?

_____ 11. vein issues, varicose veins or hemorrhoids?

_____ 12. sleep related problems, nervousness, mental conflicts of long duration?

_____ 13. exhausted, shaky, not able to concentrate or felt like energy was being drained from you?

_____ 14. nervous pain, migraines, or sensed that something bad was going to happen?

_____ 15. worn out, felt you were getting old, sensitive to sun, heat, other forms of radiation?

_____ 16. discomfort in the kidney or bladder area, or pain in low back?

_____ 17. hormonal changes, bad memory, diabetes, get up in the middle of the night, sexual disturbances?

_____ 19. skin related problems, rashes, acne, warts, cysts, unexplained itching?

_____ 20. low blood sugar, under lot of stress, feel like you have a hidden condition?

_____ 21. perspire excessively, sweaty palms, nervous tension after minor physical activity?

_____ 22. tooth decay, bone issues (osteoporosis, arthritis), calcium deficiency or hyperactivity?

_____ 23. allergies, shock, trauma, injury?

_____ 24. addictions, need a quick fix, emotionally unstable, need external remedy