Date ______

RETEST MINERAL ANALYSIS FORM

Name__________________________ Phone________________ Age ____ Height ___ Weight ___

Address _______________________________ City _______________ State/Prov. _____________

Postal Code _________ Country _____________________ Email: __________________________

A) Please follow the instructions for hair sampling carefully, and cut enough hair to balance the scale. **B)** Mark your **name**, **age** and **sex** on the small paper hair envelope. **C)** Answer the questions below. **D)** Circle your current symptoms on the symptom page. **E)** Mail your hair sample, information sheets and payment to The Center For Development, Inc. at the address below.

1. *On a scale of 0-5, how closely have you been following your program? 0=not at all 5=perfectly*
Diet___ Lifestyle___ Supplements___ Sleep___ Saunas____ Enemas___ Meditation___

2. *Describe changes you have you noticed in your symptoms or condition over the past several months.*

3. *Do you have questions in regard to your supplements, diet program, sauna therapy or coffee enemas?*

4. *Do you have questions in regard to emotional aspects, meditation or lifestyle challenges?*

5. *Are there other concerns you would like us to address when updating your healing program?*

The retest fee is $150.00 US. Add $35.00 for international orders. This includes your hair analysis, a consultation on compact disc describing your new comprehensive healing program and brief follow up phone calls or emails. Payment can be by check, money order in US dollars, or send credit card information, including expiration date and the 3 or 4-digit security code.

Mail this sheet, the hair sample and your payment to: The Center For Development, Inc.,
P.O. Box 54, Prescott, AZ 86302

Thank you! You should receive your program within about 3 weeks.

* Nutritional balancing is a means to reduce stress and is not intended as diagnosis, treatment or prescription for any condition or disease. Dr. Wilson has a medical degree and works as an unlicensed nutrition consultant only.

Dr. Lawrence Wilson and Associates
PO Box 54, Prescott, AZ 86302 USA

GENERAL INFORMATION SHEET

Name: ________________________________ **Age**____ **Sex: M or F** **Date**_________

Address____

______________________________________**City**____________________________

State/Prov.__________________ **Country** ____________________ **Postal Code**_________

Home Phone________________________ **Business Phone**___________________________

E-Mail Address____________________________________ **Height**______ **Weight**_______

Occupation___________________ **How were you referred?**_________________________

What are your main health concerns or conditions?________________________________

____

Please list any medications or food supplements you are currently taking:

____

____

Please list any recent medical tests results you have, such as blood tests:

____

Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.____

DIET: **What are examples of typical breakfasts for you?** **Beverages**

____|_________________

____|_________________

Mid-morning Snacks______________________________________|_________________

What are typical lunches for you? **Beverages**

____|_________________

____|_________________

Mid-afternoon Snacks_____________________________________|_________________

What are typical dinners for you? **Beverages**

____|_________________

____|_________________

Evening Snacks____|_________________

How often and what kind of exercise do you do?__________________________________

____

About how many hours of sleep do you get per day?_______________________________

I wish to have my program sent by ___email or ___regular mail.

I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease. Dr. Wilson has a medical degree and works as an unlicensed nutrition consultant.

Signed__________________________________ **Date**____________

Name______________________ ***SYMPTOMS SHEET***

CIRCLE any conditions or symptoms that presently describe you.
PLACE A STAR next to the symptoms most important to you.

Joint Pain
Joint Stiffness
Arthritis, Osteo
Arthritis, Rheumatoid
Muscle Pain
Muscle Weakness
Muscle Cramps
Bursitis
Fractures
Osteoporosis
Gout

Sweet Cravings
Sugar Reactions
Irritable before meals
Can't Skip Meals
Hypoglycemia
Crave Starches
Fat Cravings
Other Food Cravings
Food Allergies
Excessive hunger
No hunger
Diabetes

Rapid Heart Rate
Skipped Heart Beats
Heart Palpitations
Heart Attack
Poor Circulation
Dizziness
Low or High Blood Pressure
Angina
Arteriosclerosis
High Cholesterol______
High Triglycerides____

Cough
Bronchitis
Asthma
Post-nasal Drip
Sinus Congestion
Allergies
Emphysema

Fatigue
Hypothyroidism
Low Body Temperature
Cold in Winter/Dry Skin
Tend to Gain Weight
Hyperthyroidism

Acne
Eczema
Fungal Infections/Candida
Psoriasis
Hives
Hair Loss
Slow Wound Healing
Cataracts
Glaucoma
Other eye diseases

Hearing loss
Ringing in ears
Balance problems/dizziness
Tooth Decay
Excessive Plaque on Teeth
Gum Disease

Infections/Viruses
Tumors/Cancer
Multiple Sclerosis
Parkinson's Disease

Anger
Anxiety
Bipolar Disorder
Brain Fog
Confusion
Depression
Irritability
Mind Races
Mood Swings
Obsessive/Compulsive
Panic Attacks
Poor Memory
Schizophrenia
Trouble Sleeping
Autism
Attention Deficit
Hyperkinesis
Dyslexia
Seizures
Learning Disability
Mental Retardation
Delayed Development

Bladder Infections
Kidney Infections
Trouble Urinating
Frequent Urination
Painful Urination
Kidney Stones
Water Retention

Sinus Headaches
Tension Headaches
Migraine Headaches
Neuritis
Numbness/tingling

Constipation
Diarrhea
Intestinal Gas
Bloating
Heartburn
Ulcer
Stomach Pain
Colitis
Gall Stones
Fissures
Hemorrhoids
Cirrhosis
Diverticulosis/diverticulitis
Tend to Gain Weight
Tend to Lose Weight

Anemia
Easy Bruising

Silver amalgam dental filling
Drug Addiction
Alcoholism
Smoking

WOMEN:
Premenstrual Syndrome
Water Retention
Cramps
No Menstruation
Heavy periods
Light/Irregular Periods
Ovarian Cysts
Fibroid Tumors
Abnormal Pap Smear
Menopause
Fibrocystic Breasts
Breast Tumors
Yeast Infections
Hot Flashes
Currently pregnant
Abuse
Rape

MEN:
Prostate Problems
Impotence/erectile dysfunction
Infertility

Other Symptoms____

____ (add more paper if there is more to write)

If you have not already filled out this private membership association sheet, please do so and return it with your retest hair sample and forms

THE PRIVATE MEMBERSHIP AGREEMENT AND WHY I REQUIRE IT

In order to work with me and my associates, I now require all of our clients to join the ***Center For Development Association***. Upon signing the agreement, and our acceptance of it, you become a member for as long as the association exists.

The reason for this is that recently some state medical licensing boards or others have tried to stop the public from receiving, and practitioners from offering, alternative methods of health care, especially nutrition. This is likely due to a few unhappy doctors who feel threatened by those who may be able to heal the body without the use of toxic drugs and surgery. Instead of learning our methods, they would prefer to just stop us, even if we do no harm.

To prevent this, one method is to change your legal status from a *member of the public* to a *member of a private membership organization*. When you do this, laws that are designed "for the public" that are being misused to stop nutrition consulting, such as State Medical Practice Acts, may not apply to you. This has been upheld in courts of law, as high as the Supreme Court of the United States of America.

This change of your legal status is protected under the First, Ninth and Fourteenth Amendments to the United States Constitution. These Amendments guarantee you the right to associate, the right to assemble peacefully, and the right to contract freely with fellow members of private organizations. This can help protect your right of choice of health care and provide freedom from unwarranted interference from state and other authorities. It can also help protect and maintain your right of privacy. All private member records kept by our association are strictly protected and in most cases, may only be released upon written request of the member.

To work with us, please fill in your name below, sign at the end, and return this 2-page form with your hair sample, information sheets and payment. For minor children, a parent must sign as parent or guardian for (child's name).

CENTER FOR DEVELOPMENT ASSOCIATION **(A Private Membership Association)**
MEMBERSHIP AGREEMENT

I, ___________________________________ , hereby apply for Membership in the CENTER FOR DEVELOPMENT ASSOCIATION, hereinafter referred to as the "Association" - a private membership organization. With the signing of this agreement I accept the offer made to become a member and I express my agreement with the following DECLARATION and MEMORANDUM OF UNDERSTANDING:

DECLARATION

1. This association of members hereby declare that our primary purpose is to protect and maintain our right to freedom of choice regarding alternative therapies, alternative modalities of treatment, health care decisions and the health improvement practices that we choose to receive - by asserting our constitutional, contractual, and civil rights.
2. As members, we affirm our belief that the Constitution of the United States guarantees all Americans, particularly members of private associations, the right of freedom of association, speech, assembly, belief, and associated activities. These are our inalienable rights.
3. We declare and assert the right to select from our membership those who can be expected to give the wisest counsel and advice regarding alternative therapies, alternative modalities of treatment, health care decisions and the health improvement practices and to authorize those members who are most skilled to facilitate the actual performance and delivery of health assistance and improvement methods that they and we deem appropriate. We assert these rights under the Federal and State Constitutions, Federal and State law and the statutes and regulations interpreting them.

4. We claim our freedom to choose and accept for ourselves the types of health care modalities that we think are best for determining the cause and correction of our health challenges. We do this in order that we might achieve optimal health and well-being. We reserve the right to include traditional, non-traditional or even unconventional health care options, plus other healing modalities or techniques used by health care professionals anywhere in the world, that our member-facilitators choose to deliver - with our approval.

5. More specifically, our mission is to provide members with the highest quality health care available. Our concern is for the whole person - body, mind, and spirit. We strive to stay on the leading edge of new and better health technologies.

6. This Association recognizes all persons as members, without respect to race or religion, who are in accordance with our principles and policies. Membership is for the lifetime of this Association.

MEMORANDUM OF UNDERSTANDING

I understand that those members of the Association that provide services or advice do so in the capacity of fellow member-facilitators in a private manner and not in the capacity as public health-care facilitators. I understand that within the Association no Public-Doctor-Patient or Public-Therapy-Client relationship exists. Within the Association I freely choose to change my legal status from that of a Pub1ic Health-Care Recipient, to that of a Private Membership Association care recipient. I realize that in doing so I relinquish certain Federal and State protections and privileges. I understand that it is my personal responsibility to evaluate the services offered and to educate myself as to efficacy, risks, or desirability. I agree that the actions I take, in this regard, are my own free-will decisions. If I am accepted for membership, I will exercise my rights for my own benefit and agree to hold harmless the Association and member- facilitators from any unintentional liability that might result from the advice or services I receive, except for the harm that could remotely result from an instance of “a clear and present danger of substantive evil” - as determined by the Association and as defined by the United States Supreme Court.

I understand and accept that, since the Association is protected by the First, Ninth and Fourteenth Amendments to the United States Constitution, it is exempt from any action of Federal and State agencies entrusted to “protect the public” – as it relates to any complaints or grievances against the Association, its physical premises or equipment its Trustees, member-facilitators or other associated staff or consultants. All complaints or grievances will be settled by non-judicial mediation, within the Association. Also, those membership and private member records kept by the Association are strictly protected and can only be released upon written request of the subject member.

I agree that I am joining this Private Membership Association under the common law. I understand that members seek to help each other achieve and sustain better health. I accept that the facilitators, and other health-care providers, who are fellow members, offer advice, services, and benefits that are not necessarily conventional or traditional.

As a Member, my goal is to accept those health and wellness services that I feel will truly help me. I will choose procedures that I consider proper and have a reasonable chance of making my health and life better. I realize that no health screening, resulting conclusions or health care services are foolproof. For example, if I choose to forego drugs, surgery or symptom treatments that have been recommended by others, in the public sector, I accept that risk. I assert my right of informed consent.

My activities within the Association are a private matter and I refuse to share them with any Federal or State regulatory enforcement agency, medical board, FDA, Medicare or Medicaid. The health and/ or sickness records that I have shared with other members remain the property of the Association. I, in becoming a member, agree not to file malpractice, civil or criminal lawsuits against a fellow member, unless that member exposes me to a clear and present danger of substantive evil. I further agree that all association members are exempt from the provisions of any state Medical Practices Act, Federal Food Safety Modernization Acts, Codex Alimentarius or any similar federal or state legislation.

I enter into this agreement of my own free will, or on behalf of a designated dependent, without any pressure or promise of benefit. I affirm that I do not represent any state or federal agency whose purpose is to regulate the practice of medicine or any other health care system. I accept that membership does not entitle me to any voting interest in the Association. I acknowledge I am not liable for any debts, liabilities, suits or judgments against the Association.

I have read and understand this contract and any questions I had were answered fully to my satisfaction. This document consists of my entire agreement for membership and it supersedes any previous agreement I may have made.

I understand that my membership fee entitles me to receive those benefits declared by a Trustee to be general benefits, free of further charge. I also agree to pay, as levied, for those benefits that I request and receive that are declared to be special assessments, as per a posted fee schedule.

I understand that $25.00 (twenty-five dollars) of my consulting fee is consideration for my membership, said term of membership beginning with the date of the signing and acceptance of this agreement and continuing until the dissolution of this association. By these presents I do certify, attest, and warrant that I have carefully read this application for membership and I fully understand and agree with all of the provisions stated herein.

IN WITNESS WHEREOF I set my hand on this the __ day of __________________ , 20____

Print Applicant’s Name: ____

Applicant’s Signature: ____