

Client Forms and Information

The First Appointment:

Plan on approximately 2 hours.

- Bring all vitamins, minerals, supplements and medications you're currently taking.
- Please don't take anything, except necessary medication for 24 hours before your appointment.
- Avoid lotions on your hands and feet the day of testing.
- Drink water before your appointment as dehydration makes it difficult to obtain accurate readings.
- Please eat within two hours of your appointment so your blood sugar is level.
- Avoid caffeine for a minimum of 4 hours before testing. 24 hours is best.



Please print out the following health history and have it completed when arriving for your first appointment.

CLIENT HEALTH QUESTIONNAIRE

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Phone Number: (Home) _____ (Work) _____
Date of Birth: _____ (Fax) _____
Occupation: _____ Employer: _____
How did you hear about us? _____
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Please list your current health concerns in order of importance:

1. _____
2. _____
3. _____

Major illnesses: _____

Medical Tests completed in the last 12 months? _____

Have you received a medical diagnosis for your condition? Yes ___ No ___

Are you Pregnant? Yes ___ No ___ Are you currently breastfeeding? Yes ___ No ___

Number of Children _____ Any miscarriages in the past? _____

Caffeinated beverages per day? _____ Alcoholic beverages per day? _____

Do you use artificial sweeteners? _____ Drink diet pop? _____ Chew gum? _____

Do you use soy products? _____ Are you a vegetarian? _____

Do you eat organic natural foods? _____ Do you smoke? _____

Please rate your stress levels on a scale of 1 to 10 during the average week: _____

What medications are you currently taking? _____

Rate your energy level 1 to 10 (10 is the best) _____

Do you often wake up in the middle of the night? _____

Is it at a certain time? _____ If yes, When do you wake? _____

Have you ever had Epstein-Barr or Mononucleosis? _____

Do you use aluminum cookware? _____

Do you have a water softener? _____

CHECK ALL THAT CURRENTLY APPLY:

- Recurrent Sinus Infections
- Post Nasal Drip
- Swollen Lymph Nodes

Recurrent Respiratory Infections

Coughs

Bronchitis

Pneumonia

Asthma

Number of bowel movements per day

Bouts of Diarrhea

Constipation

Bloating

Gas

Coated Tongue

Irritable Bowel Syndrome

Crohn's Disease

Feeling that bowels don't empty completely

Pain, tenderness, soreness on left side under rib cage, bloated

Nausea and/or vomiting

Stool undigested, foul smelling, mucous-like greasy or poorly formed

Frequent urination

Increased thirst and appetite

Yeast Infections

Last Antibiotic used? _____ How long ago? _____

Difficulty digesting fruits and vegetables, undigested foods found in stools

Stomach pain, burning or aching 1-4 hours after eating

Frequent use of antacids

Feeling hungry an hour or two after eating

Heartburn when lying down or bending forward

Temporary relief from antacids, food, milk, carbonated beverages

Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine

Greasy or high fat foods cause distress

Bitter metallic taste in mouth, especially in the morning

Stool color alternates from clay colored to normal brown

History of gallbladder attacks or stones

Have you had your gallbladder removed? Yes ____ No ____

Crave sweets during the day

Depend on coffee to keep yourself going

Get lightheaded if meals are missed

Feel shaky, jittery, or irritable if meals are missed

Poor memory, forgetful

Blurred vision

Fatigue after meals

Jaundice

High Cholesterol

Blood disorders

Chronic fatigue

Recurrent infections

Lowered immune response

Palpitations

Arrhythmia

Heart surgery

High blood pressure

Low blood pressure

Varicose veins

Arteriosclerosis

Sensitivity to:

Pollens

- Molds
- Seasonal irritants
- Perfumes
- Animal Dander
- Foods
- Rashes
- Dry or flaky skin and or hair
- Eczema
- Acne
- Psoriasis
- Fungus
- Warts

- Cannot stay asleep
- Crave salt
- Slow starter in the morning
- Dizziness when standing up quickly

- Headaches with exertion or stress
- Weak nails
- Cannot fall asleep
- Perspire easily

- Tired, most of the time
- Wake up tired even after 7 or more hours of sleep
- Gain weight easily
- Depression, lack of motivation
- Thinning of hair
- Inward trembling
- Increased pulse even at rest
- Nervousness and emotional
- Night sweats
- Difficulty gaining weight

• Men Only

- Urination difficulty
- Frequent urination
- Muscle soreness
- Increase in fat distribution around chest and hips
- Sweating attacks
- More emotional than in the past

• Menstruating Women Only

- Peri-menopausal
- No menstrual cycle
- Extended menstrual cycle, greater than 32 days
- Shortened menses, less than every 24 days
- Excessive pain and cramping during periods
- Scanty blood flow
- Heavy blood flow
- Irritable and depressed during menses
- PMS
- Miscarriages
- Infertility

• Menopausal Women Only

- How many years have you been menopausal? _____
- Do you ever have uterine bleeding since menopause? Yes ___ No ___
- Hot flashes
- Disinterest in sex
- Mood swings
- Depression
- Acne

- Fibromyalgia
- Carpal tunnel
- Bone or joint disease
- Tendonitis
- Bursitis
- Broken/fractured bones
- Arthritis
- Sprains/ strains
- Low back, hip, leg pain
- Neck, shoulder, arm pain
- Headaches, head injuries
- Jaw pain, TMJ

Anything else: _____

Waiver of Liability Form for Services Rendered at
The Physics of Health, LLC.

I, the client choose to receive a meridian screening using EAV (Biomeridian) test equipment. The opinions received may include information on stress reduction, nutritional suggestions, including suggested supplements or homeopathics. I agree to communicate with Trish Watson any concerns I have before or after involving the testing.

I understand that Trish Watson does not treat, diagnose illness, disease, or any physical or mental disorder, nor does she prescribe medical treatment or pharmaceuticals. I acknowledge that any opinions from Trish Watson are not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that service.

I also further understand that Trish Watson is not a doctor, dietitian, or medical professional. Any opinions on dietary changes, or restrictions including supplementation of any kind is to be done at my own risk. If I have any concerns or ill effects after the meridian screening or from the use of any supplements, I will call Trish immediately.

All medical information given is strictly confidential.

I have read and understand the policies for services received at The Physics of Health, LLC

Print Name: _____

Client Signature: _____ Date _____

Thank You.

Trish Watson, CNC