## 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) _____ (Cell) _____
Date of Birth: _____ (Fax) _____
Occupation: _____
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?_____ Non-stick cookware? Yes ☐ No ☐
Do you have a water softener? _____
Do you use anti-persporant? Yes ☐ No ☐

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? _____

☐ Do you eat sushi
☐ 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 or 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 screenings using EAV (Biomeridian), Zyto and EVOX testing equipment. The opinions received may include information on stress reduction, nutritional suggestions, including suggested supplements or homeopathic type products. 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, or dietary changes I will call Trish immediately.
All information given by you, the client is confidential and will not be shared for any reason.

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