Client Health Questionnaire

Name:

Address:

City: State: Zip:

Home Phone:

Date of Birth: Cell: Fax:

Email Address:

Occupation: Emergency Contact: Phone:

Employer: Phone:

Primary Care Physician: Phone:

Referred by:

Please list your current health concerns in order of importance:

1.

2.

3.

List any major illnesses:

List any Medical Tests completed in the last 12 months:

Have you received a medical diagnosis for your condition? Yes_ No_

Are you Pregnant? Yes_ No_

Number of Children:

Do you consume caffeinated beverages? Yes_ No_

If yes, how much and how often?

Do you consume alcoholic beverages? Yes_ No_

If yes, how much and how often?

Do you use artificial sweeteners? Yes_ No_

Drink diet pop? Yes_ No_

Chew gum? Yes_ No_

Do you use soy products? Yes_ No_

Are you a vegetarian? Yes_ No_

Do you eat organic natural foods? Yes_ No_

Do you use tobacco of any kind? Yes_ No_

If yes, what kind and how much?

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

Are you taking any medications? Yes_ No_ If yes, please list below.

Please rate your energy level on a scale of 1 to 10:

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

Is it at a certain time? Yes _ No_

If yes, when do you wake?: AM/PM

Have you ever had Epstein-Barr or Mononucleosis? Yes_ No_

Have you ever had Strep Throat? Yes_ No_

Do you use aluminum or non-stick cookware? Yes_ No_

Please check all that currently apply:
Recurrent Sinus Infections
Respiratory Infections
Post Nasal Drip
Swollen Lymph Nodes
Coughs
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
Indigestion
Pain, tenderness, soreness on left side under rib cage
Nausea and/or vomiting
Stool undigested, foul smelling, mucus-like greasy or poorly formed
Frequent urination
Increased thirst and appetite
Yeast Infections
Last Antibiotic used? How long ago?
Difficulty digesting fruits and vegetables
Stomach pain, burning or aching 1-4 hours after eating
Frequent use of antacids
Feeling hungry an hour or two after eating
Heartburn or acid reflux
Heartburn due to spicy foods,chocolate, citrus, peppers, alcohol and caffeine
Greasy or high fat foods cause distress
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 or get started
Get lightheaded if meals are missed
Feel shaky, jittery, or irritable if meals are missed
Blurred vision
Jaundice
High Cholesterol
Chronic fatigue
Lowered immune response/recurrent infections
Palpitations
Arrhythmia
Weak Valves
Heart surgery
Cold fingers and/or toes
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
Morning or Afternoon headaches
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
Morning headaches that wear off as the day progresses
Thinning of hair or hair loss
Mental sluggishness/ foggy head, can't concentrate, forgetful
Inward trembling
Increased pulse even at rest
Nervousness and emotional
Night sweats
Difficulty gaining weight
Increased or Decreased Libido

All Genders
Fibromyalgia
Carpal tunnel
Bone or joint disease
Tendonitis
Bursitis
Broken/fractured bones
Arthritis
Low back, hip, leg pain
Neck, shoulder, arm pain
Headaches, head injuries
Spasms, cramps
Jaw pain, TM

Men Only
Urination difficulty or dribbling

Frequent urination
Pain inside legs or heels
Decrease in libido
Muscle soreness
Decrease in physical stamina
Increase in fat distribution around chest, stomach and/or hips
Sweating attacks
More emotional than in the past

Menstruating Women Only

Perimenopausal
No menstrual cycle
Extended menstrual cycle, greater than 32 days
Shortened cycle, less than every 24 days
Excessive pain and cramping during periods
Scanty blood flow
Heavy blood flow
Breast pain and swelling during cycle
Irritable and depressed during cycle
PMS
Infertility

Menopausal Women Only

How many years have you been menopausal?
Do you ever have uterine bleeding since menopause?
Hot flashes
Disinterest in sex
Mood swings
Depression
Painful intercourse
Shrinking breasts
Facial hair growth
Increased vaginal pain, dryness or itching

Waiver of Liability for Services Rendered by Marilyn Giragosian at Health and Wellness Consultants, Inc.

I, the client choose to receive a wellness screening using EAV testing equipment. I realize that the treatment or dietary advice is being given for the well being of my body. This includes but is not limited to stress reduction, nutritional information, increased sense of well-being and/or quality of life. I agree to communicate with **Marilyn Giragosian** any concerns I have involving the testing.

I understand that **Marilyn Giragosian** does not diagnose illness, disease, or any physical or mental disorder, nor does she prescribe medical treatment or Pharmaceuticals. I acknowledge that any treatment from **Marilyn Giragosian** is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care

provider for that service.
I also further understand that **Marilyn Giragosian** is not a doctor. Any advice 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 screening or from the use of any supplements, I will call Marilyn immediately.
I have stated all pre-existing and existing medical conditions and medications that I am presently taking and will update **Marilyn Giragosian** of any changes in my health status

*Individuals who do not cancel their appointment within 24 hours will be charged a $20 cancellation fee.

Print Name:

Client Signature: Date:

In health and happiness,

Marilyn Giragosian, RN, BSN, CBEP