Client Data Form

Janet Christmas – Registered Holistic Nutritionist

Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Gender: Male Female

What are your main health concerns/complaints that bring you here today?

_____

_____

_____

Occupation: _____

Do you enjoy your work? _____

Have you recently experienced and emotional loss? _____

_____

What level of stress do you feel at this time? Mild Average High

What are all the major factors contributing to your stress? (Circle all that apply)

Career Family Marriage Personal

Health Financial Spiritual

Other (specify): _____

Is this stress immediate or on-going? Immediate On-going

Do you exercise? What kind of exercise do you do? _____

_____

How many hours of sleep do you get on average? _____

Do you feel rested upon awakening? Yes No

Do you smoke? Yes No

Does anyone in your home or workplace smoke? Yes No

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How many hours per day do you spend:

Watching television _____ Driving _____

Reading _____ In front of the computer _____

Medical History

List any medications (prescribed or over-the-counter) that you are currently taking:

_____

_____

List any vitamins, minerals, herbal or homeopathic remedies you are currently taking:

_____

List any known allergies you have: _____

_____

Have you ever been diagnosed with an illness? _____

_____

Have you ever been hospitalized? _____

_____

Do you use recreational drugs? Yes No

If yes, **how often and what type?** _____

Have you ever been treated for drug or alcohol dependency? Yes No

Have you ever been diagnosed with and of the following medical conditions?

Heart disease	Yes	No	Hypertension	Yes	No
Glaucoma	Yes	No	Asthma	Yes	No
Diabetes	Yes	No	Arthritis	Yes	No
Osteoporosis	Yes	No	Ulcers	Yes	No
Allergies	Yes	No	Mental illness	Yes	No
Kidney dysfunction	Yes	No			
Digestive gas, bloating, cramping, constipation or diarrhea				Yes	No
cancer	Yes	No			

If yes what type of cancer? _____

Other concerns (please list) _____

_____

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Females:

Are you or could you be pregnant?	Yes	No
Are you menopausal?	Yes	No
Are you experiencing menopausal symptoms?	Yes	No
Have you had a bone density test?	Yes	No
If yes, what were the results of the test?	_____	
Do you suffer from dysmenorrhea (painful periods)?	Yes	No
Do you suffer from amenorrhea (lack of menstruation)?	Yes	No
Do you experience any menstrual irregularities?	Yes	No

Please note that all patient information if kept confidential

The information provided is for consultation purposes and this statement is being signed voluntarily

BIOMERIDIAN DISCLOSURE AND LIMITATIONS

By participating in this BioMeridian (MSA) screening and singing below, I acknowledge that the information should not be interpreted as medical diagnosis or recommendation for a specific treatment plan or a course of action. It cannot replace the advice of my own physician. I am authorizing Janet Christmas R.H.N. to perform the test being offered for comparison of general health effects before and after taking supplements. I also acknowledge that this is a screening test only and if any conditions exist that are not detected, Janet Christmas R.H.N. shall not be held liable without prejudice. My information will be kept confidential and not shared or disclosed.

Date: _____

Signature: _____

Name (please print) _____