Meridian Stress Test Questionnaire

Date_____

Name_____Phone #'s_____

Address_____

_____

E-mail_____

Referred by_____

Age_____ Female_____ Male_____Height _____ Weight_____

Do you exercise _____What type of exercise and how often _____

_____

Occupation_____ Do you like your work ____

Do you have any children _____How many ____ Ages of children_____

Are you a caregiver for anyone else____ Who_____

List your top 5 complaints and how long you have had them in order of importance.

Rate the intensity of symptoms from 1-10. 10 would be most often and intense and 1 being less often and mild.

_____

_____

_____

_____

_____

Does anyone else in the family have the same complaints _____

Have you been vaccinated _____ Do you get flu shots _____

Have you received military vaccinations _____

Where were you stationed_____ Branch of service_____

Are you seeing an MD for any complaints _____

Surgical History_____

_____

_____

Circle which applies. Do you have any surgical pins, scars or implants. Location:

_____

Do you have a pacemaker or other electrical medical device _____

Have you had dental surgery in the past year_____What type_____

Do you have metal fillings_____

Have you had your fillings removed and replaced with composite _____

Does your deodorant contain aluminum _____

Have you ever done a heavy metal detoxification _____

If yes, explain method used_____

Rate your emotional health or happiness now.

10 being the best and 1 being the worst. _____

Rate your childhood using the same rating system as the last question. _____

Circle which applies. Do you experience anxiety, depression, panic, or insomnia.

Do you have any past drug use that you would like to address_____

_____

Do/did you breast feed ____

Do/did you take birth control pills ____

Do you have painful periods _____

Do you experience PMS ____

Do you have fibroids _____

Are you in menopause_____

_____

Do you get up in the middle of the night to void _____ how many times _____

Circle which applies. Describe your bowel routine, daily, weekly, other_____

Bleeding _____ Pain _____Describe Consistency_____

Have you traveled outside the country _____ or, to a tropical region Florida____

Africa _____

Medications you are currently on and for what body systems:

_____

_____

_____

_____

Do you have MRSA _____ Do you have an autoimmune disorder _____

Do you have anything else important that needs to be addressed _____

_____

Do you take supplements, if so, bring them with you in their bottles, if you take powders in large tubs put a scoop in a baggie and seal it.

Please list your daily water intake and type of water: _____

Circle which applies. Do you crave the following items: Sugar, alcohol, starches, chocolate, salty, or crunchy foods

What is your status on diet drinks, do you drink them now ____ If in the past, what length of time did you drink them_____

Did you or are you currently taking diet pills. If so, please name: _____

Describe an average day of meals and snacks for you:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____