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 composites? _____

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, please list them and write what you're taking them for.

_____

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_____

Informed Consent Statement

I, _____, hereby attest and agree to the following;

I fully understand that Robin Ball, Certified MSA Technician, deals strictly in helping people improve their general health through better nutritional approaches, improved lifestyle, improved health habits and positive mental attitudes.

I fully understand that, Robin Ball, is not a licensed physician and cannot diagnose diseases, prescribe drugs or recommend treatments for specific disease conditions.

I understand that all evaluations/ analysis performed by Robin Ball are designed to evaluate my inherent constitution and temperament for the sole purpose of helping me to improve my general health through nutrition, habits, and attitudes. I further understand that all evaluations/ analysis cannot determine specific disease conditions, and do not replace the diagnostic services offered by licensed physicians.

I understand that, Robin Ball, neither claims nor implies that any instruction, advise, counsel, suggestions, recommendations, services or products she provides, whether in person, by mail or by telephone, will cure, treat, prevent or migrate any disease condition; but are provided solely for the purpose of increasing energy, supporting the natural functions of body systems and otherwise improving general health and fitness.

I certify that Robin Ball has not suggested that I cease any medical care I may be undertaking. I understand that decisions I make regarding my health care and the health care of those under my guardianship are my responsibility and certify that I will not hold Robin Ball responsible for the consequences of my decisions.

I certify that I am here on this and on any subsequent visits or contact, whether by mail, telephone, or in person, solely on my own behalf and not as an agent or representative of any federal, state, county, or local government or private agency on a mission of investigation.

I have read and understand the foregoing and agree to the terms and conditions set therein.

Client Signature_____ Date_____

Referred by_____