The Holistic Wellness Center – Biomeridian Assessment

Statement of Intent:
I, Dr. Sandra (Sandi) Queen, am a Doctor of Naturopathy and Educator, not a physician. I do not diagnose or treat a disease. I assist my clients in their desire to support the innate healing response of their body by educating them about individual selection of food, herbs, nutrition supplements, relaxation, and exercise programs.

Client Information: Date: _____

Name: _____

Address: _____

_____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Gender: ___M ___F

Parent/Guardian (if a minor): _____ Phone: _____

Has Parent/Legal Guardian Given Permission for Child's Appointment Today? _____

Emergency Contact: _____ Phone: _____

Relationship to Client: _____

Primary Care Physician: _____ Phone: _____

Are you currently under the care of a health professional for any health, medical, or emotional condition? _____ If so, for what problem(s) or condition(s)? _____
_____
_____

DO YOU HAVE A PACEMAKER OR OTHER ELECTRICAL DEVICE INSTALLED IN YOUR BODY? _____ IF SO, YOU ARE NOT A CANDIDATE FOR BIOMERIDIAN ASSESSMENT.

DO YOU, OR HAVE YOU IN THE PAST, HAD SEIZURES OF ANY KIND? _____
IF SO, YOU ARE NOT A CANDIDATE FOR BIOMERIDIAN ASSESSMENT.

Occupation: _____

Job activities:
_____
_____
Hobbies:
_____

Describe a typical day's meals for you, including portion sizes:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Circle any of the following consumed, and list how frequently they are consumed:

Caffeine _____ Sugar _____Alcohol _____

Illegal Drugs _____ OTC Drugs _____Prescription Drugs _____

Fried Foods _____ Grilled Meats _____

White Flour _____ Processed Meats (hot dogs, lunchmeat, bacon) _____

Artificial Sweeteners _____ Artificially Colored Foods _____

Juice/Juice Drinks _____ Dairy Products _____

Do you smoke? _____ If so, how often? _____

Do you use other tobacco products? _____ If so, how often? _____

Are you exposed to second hand smoke? If so, how often? _____

What time to you typically go to sleep? _____

Do you work nightshift? _____ How many hours to you tyically sleep? _____

Do you have trouble falling asleep? _____ Trouble staying asleep? _____

Do you feel refreshed when you awaken? _____

What type of water do you drink (distilled, spring, city tap water, etc.) _____

How much pure water do you typically drink in one day? _____

What is(are) your major complaint(s)? What changes have you noticed with your body? List medications: Any organs or parts removed?

_____

_____

_____

_____

Circle any of the following which you have been diagnosed with or had problems with:

Anemia Cancer Diabetes Prostate Allergies

Rashes Frequent Infections Headaches Edema

Heart Attack Stroke High/Low Blood Pressure Dizziness

Kidney Disease Liver Disease Menstrual Irregularities Asthma

Haitus Hernia Arthritis Hypothyroid Hyperthyroid

Autoimmune Disease Fainting Bleeding Menopause Issues

High Cholestrol Gastrointestinal Issues Heartburn Numbness

Osteoporosis Constipation Diarrhea Indigestion

Other Health Issues: _____
_____

List all physical, emotional, or medical issues you've experienced in the last three years:
_____
_____
_____
_____

Have any family members within 2 generations had cancer? _____ If so, who, and what kind? _____

In a 25 mile proximity to your home, are there any: (circle any that apply)

Landfills High Tension Electric Lines Nuclear Waste Facilities Chemical Plants

Gasoline Storage Tanks Areas Sprayed With Pesticides or Herbicides High Traffic Areas

Other Areas of Known Toxicity: _____

Do you exercise? _____ If so, how frequently? _____

What types of exercise do you do? _____
_____
_____

List any allergies (food, environmental, etc.) _____
_____
_____

List any herbal or other supplements, amounts, and how frequently you take them:
_____
_____

List any prescription drugs you take regularly, including dosages: _____
_____
_____

Have you had any surgeries or hospitalizations? If so, list when, and what the nature was: _____
_____
_____

I have provided all of my known physical and medical conditions. I understand that the client consultation with Dr. Sandra (Sandi) Queen, ND is for educational purposes only, and not for diagnostic or treatment purposes. I give my consent to participate in this and future consultations, and will not hold Sandra (Sandi) Queen responsible for the outcome of any choices I make resulting from the education I receive during these consultations. I fully understand that Dr. Sandra (Sandi) Queen, ND is not a medical doctor, and is not making recommendations, diagnosis, or other suggestions, nor prescribing any medications or other substances, and that any services or products I choose to incorporate into my lifestyle are due to my own choices. I understand that any information shared in consultations in the offices of The Holistic Wellness Center are not meant to take the place of medical care or treatment for any health or emotional problem or condition, but is soley for the purpose of supporting wellness in my body through the empowerment of education, and any choices that are made are made by myself alone, on my own behalf.

Client Signature _____ Date _____

Print Name: _____

If Client is a Minor Child, Signature of Parent or Legal Guardian:

_____Printed Name of Minor:_____

How much time do you spend relaxing:

Daily?_____ Weekly?_____ Monthly? _____

What do you do to relax? _____

When taking supplements, I prefer: ___pills ___liquids ___essential oils

___a variety ___doesn't matter

Stress Indicators:

On a scale of 1 to 10, with 1 being the least and 10 being the most, rate the amount of each of the following stressors. Do not label the stressors from 1 to 10, but rather rate each one individually from 1 to 10.

___poor quality sleep ___not enough sleep ___getting to sleep after 11 PM

___poor diet ___exposure to toxins ___exposure to negativity or anger

___death of loved one ___divorce ___other family stress ___other lifestyle stress

___exposure to things to which you are allergic

My family life stress is:	___none	___minimal	___moderate	___severe
My relationship stress is:	___none	___minimal	___moderate	___severe
My work stress is:	___none	___minimal	___moderate	___severe
My financial stress is:	___none	___minimal	___moderate	___severe
My physical stress is:	___none	___minimal	___moderate	___severe
My health stress is:	___none	___minimal	___moderate	___severe
Other stress_____ is:	___none	___minimal	___moderate	___severe

I understand that this questionnaire is for educational purposes, and that Dr. Sandra (Sandi) Queen, ND, is not a medical doctor, psychologist, or psychiatrist, and is not making recommendations, but merely educating me for my own interest. I am choosing to order and take any supplements. I understand that, if I am experiencing emotional or mental issues that need the intervention of a licenced professional in this field, Queen Homeschool Supplies, Inc., Dr. Sandra (Sandi) Queen, ND, and The Holistic Wellness Center and all owners and employees recommend that I see a qualified professional instead of, or in addition to, taking this remedy. This remedy is not meant to take the place of professional mental or emotional help.

_____ _____

Signature Date

PAYMENT IS EXPECTED IN FULL WHEN SERVICES ARE RENDERED.

We accept cash, credit card (Mastercard, Visa, or Discover), and, once you are an established customer, we will accept your check in US funds. Returned check fee is $25.00. If you pay by credit card, your credit card statement will read: **Queen Homeschool Supplies, Inc.**, which is the parent company of The Holistic Wellness Center.

I understand these terms:

_____ _____

Signature Date