SALVEO HOLISTIC WELLNESS

HEALTH ASSESSMENT

The purpose of the Health Assessment is to identify dietary sources of stress that affect the normal functions of the body and are producing symptoms. We seek to find the cause of these symptoms and make appropriate recommendations for their correction before they lead to more serious problems.

This questionnaire is lengthy, but it is an important step in your assessment. Once you have completed the questionnaire, please email, fax or mail it to our office at least one week prior to your visit so we can have adequate time to review it. Thank you for your cooperation.

Salveo Holistic Wellness

NAME _____ DATE _____

ADDRESS _____CITY, ZIP_____

CELL _____HOME PHONE _____

EMAIL_____AGE_____ GENDER_____

OCCUPATION _____MARITAL STATUS _____

SPOUSE'S or PARENT'S NAME _____

EMERGENCY CONTACT _____ PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

Please read the following and sign below:

The Biomeridian system, palpation and muscle testing provide non-invasive methods for gaining valuable information about areas of weakness in the body. The primary objective is to identify those areas of weakness and educate about natural remedies and methods to nourish and balance the body. I give my permission to be evaluated with the Biomeridian system, palpation or muscle testing.

I understand that I am not here for, nor will I receive a medical diagnosis and the practitioner is not a medical doctor and is not becoming my primary care physician. If you need medical intervention or treatment, you should consult your medical doctor. I am not, on this visit or any subsequent visit, a representative for federal, state or local agencies on a mission of entrapment or investigation.

I understand that I am here to learn about better health and health practices. I will be offered information about nutritional dietary supplements as a guide to good health. This service is offered as a personal ministry. Any decision to follow through with the program will be my own decision, and I will not hold the CNHP or Salveo, LLC liable. I have read, fully understand and agree with the above listed information.

Client Signature_____

Date_____

Your Health History: *Circle or highlight all that are applicable*

AIDS/HIV	Chem Dependency	Hernia	Pacemaker	Tonsillitis
Alcoholism	Chicken Pox	Herniated Disc	Parkinson's Disease	Tuberculosis
Anemia	Depression	Herpes	Pneumonia	Tumors, Growths
Anorexia	Diabetes	Kidney Disease	Polio	Ulcers
Appendicitis	Emphysema	Liver Disease	Prostate Problems	Vaginal Infections
Arthritis	Epilepsy	Measles	Psychiatric Care	Venereal Disease
Asthma	Fractures	Migraines	Rheumatoid Arthritis	Whooping Cough
Bleeding Disorders	Glaucoma	Miscarriage	Rheumatic Fever	Other_____
Bronchitis	Goiter	Mononucleosis	Scarlet Fever	_____
Bulimia	Gout	Multiple Sclerosis	Stroke	_____
Cancer	Heart Disease	Mumps	Suicide Attempt	_____
Cataracts	Hepatitis	Osteoporosis	Thyroid Problems	_____

Surgeries/Date:_____

_____

_____

Current Medications and Supplements: _____

_____

_____

Please list your main **Health Concerns** in order of importance:

1. _____

2. _____

3. _____

Health Goals:

_____

_____

_____

Do you have amalgam (silver) dental fillings? _____Yes _____No

How Active are you? No Activity Low Activity Moderate Activity High Activity

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

Do you drink alcoholic or caffeinated beverages? _____Yes _____No

If so, what kind_____ How often?_____

How many ounces of water do you drink daily? _____

List any know allergies:_____

Have you received the Covid-19 vaccine?_____Yes_____ No **Any Boosters?**_____Yes_____No

Dietary Preferences:

List foods you crave: _____

_____

List foods you avoid: _____

_____

Do you normally eat three meals? _____Yes _____No

If not, which meal do you skip _____

Do you chew gum or use breath mints daily? _____Yes _____No

For Women:

Are you pregnant? _____Yes _____No

Are you nursing? _____Yes _____No

Are you in menopause? _____Yes _____No

HEALTH QUESTIONS

Please read each symptom carefully and mark your answers as follows:
1 – this is a MINOR problem (occurs occasionally)
2 – this is a MODERATE problem (occurs more than occasionally)
3 – this is a SEVERE problem (occurs frequently)
Leave it blank for no symptom

GROUP ONE:

___ "Nervous" Stomach
___ Not mentally alert
___ Cold sweats often
___ Dry mouth, eyes, nose
___ Extremities cold, clammy
___ Fever easily raised
___ Pulse speeds after meal
___ Heart pounds after retiring
___ Nerve pains
___ Keyed up; hard to calm
___ Acid foods upset
___ Symptoms made worse by emotional stress?

TOTAL _____

GROUP TWO:

___ Perspire easily
___ Digestion rapid
___ Joint stiffness after rising
___ Muscle/leg/toe cramps
___ Vomiting frequent
___ Poor circulation/sensitive to cold
___ Eyelids swollen, puffy
___ Difficulty swallowing
___ Subject to colds/asthma/ bronchitis
___ Indigestion soon after meals
___ Constipation, diarrhea
___ Symptoms made worse by physical stress?

TOTAL _____

GROUP THREE:

___ Afternoon headaches
___ Heart palpitates if meals missed or delayed
___ Crave candy or coffee in afternoons
___ Faintness if meals missed or delayed
___ Awaken after few hours' can't get back to sleep
___ Abnormal craving for sweets or snacks
___ Get "shaky" if hungry

TOTAL _____

GROUP FOUR:

___ Bruise easily
___ Swollen ankles
___ Hands & feet go to sleep
___ Sigh frequently
___ Muscle cramps
___ Breath heavily
___ Shortness of breath
___ Tendency to anemia
___ Susceptible to colds/fevers
___ Opens window in rooms
___ Dull pain in chest or radiating into left arm
___ Tightness under breastbone

TOTAL _____

GROUP FIVE:

___ Dry skin
___ Constipation, headaches
___ Laxatives used often
___ Skin rashes frequent
___ Greasy foods upset
___ Stools light colored
___Gallbladder attacks/stones
___ Pain between shoulder blades
___ Sneezing attacks
___ Bitter metallic taste in mouth in mornings
___ Bowel movements painful or difficult

TOTAL _____

GROUP SIX:

___ Lower bowel gas after eating
___ Gas shortly after eating
___ Coated tongue
___ Burning stomach sensations, eating relieves
___ Stomach "bloating" after eating
___ Indigestion after eating; may continue for 3 or 4hrs

TOTAL _____

GROUP SEVEN:

(A)

___ Pulse fast at rest
___ Nervousness
___ Can't gain weight
___ Intolerance to heat
___ Highly emotional
___ Flush easily
___ Night sweats
___ Inward trembling
___ Heart palpitates
___ Insomnia
TOTAL _____

(B)

___ Impaired hearing
___ Decrease in appetite
___Ringing in ears
___ Constipation
___ Mental sluggishness
___ Headaches in AM, wears off
___ Slow pulse, below 65
___ Increase in weight
TOTAL _____

(C)

___ Low blood pressure
___ Failing memory
___ Increased sex desire
___ Headaches
___ Decreased sugar tolerance
TOTAL _____

(D)

___ Bloating of intestines
___ Abnormal thirst
___ Weight gain hips/ waist
___ Sex desire reduced/lacking
___ Delayed menstruation
___ Tendency to ulcers
___ Increased sugar tolerance
___ Menstrual disorders
TOTAL _____

(E)

___ Hot flashes
___ Headaches
___ Dizziness
___ High blood pressure
___ Sugar in urine (not diabetes)
___Masculine tendencies (if female)
TOTAL _____

(F)

___ Low blood pressure
___ Chronic fatigue
___ Weakness, dizziness
___ Tendency to hives
___ Arthritic tendencies
___Perspiration - easily
___ Crave salt
___ Brown spots on skin
___ Allergies/asthma
___Exhaustion
___Respiratory issues
TOTAL _____

GROUP EIGHT:

(Females only)

___ Painful menses

___ Premenstrual tension

___ Very easily fatigued

___ Depressed before menses

___ Menstruation excessive

___Menopause, hot flashes

___ Painful breasts

___ Menstruate too frequently

___Vaginal discharge

___Menses scanty

___Acne, worse at menses

TOTAL_____

(Males only)

___ Tire too easily

___ Urination difficult at night

___ Night urination frequent

___ Pain on inside of legs or heel

___ Feeling of incomplete bowel evacuation

___ Diminished sex desire

___ Prostate trouble

___ Leg nervousness

TOTAL _____

GROUP NINE:

___ Chronic cough

___ Pain around ribs

___ Shortness of breath

___ Chest pain

___ Difficulty breathing

___ Coughing up phlegm

___ Coughing up blood

___ Sensitive to smog

___ Bronchitis (frequent)

___ Infections settle in lungs

TOTAL _____

GROUP TEN:

___ Frequent urination

___ Rose colored (bloody)

___ Dripping after urination

___ Difficulty passing urine

___ Cloudy urine

___ Rarely need to urinate

___ Strong smelling urine

___ Frequent bladder infections

___Painful/burning when passing urine

___ Urination when you cough or sneeze

TOTAL _____

GROUP ELEVEN:

___ Throat infections
___ Gets boils or styes
___ Bumpy skin on back of arms
___ Poor wound healing
___ Swollen lymph glands
___ Inflamed/bleeding gums
___ Slow to recover from colds or flu
___ Catch colds or flu easily
___ Hyperactivity
___ Chronic lung congestion
___ Breathe through mouth
___ Food sensitivity or allergies
___ Post nasal drip
___ Swollen tongue

TOTAL _____

GROUP TWELVE:

___ Repeated courses of antibiotics
___ Recurrent digestive problems
___ Chronic skin rashes
___ Crave sugar/bread/alcohol
___ Fatigue or lethargy
___ Muscle weakness
___ Sensitive to tobacco, perfume, chemical odor
___ Worse on muggy days or in moldy places

TOTAL _____

GROUP THIRTEEN:

___ Increased secretions in mouth/nose/eyes
___ Water gain/swelling in hands and feet
___ Cold hands/feet
___ Muscle cramps at night
___ Chronic low back pain
___ Bleeding gums
___ Difficulty healing after injury
___ Loss of taste for meat

TOTAL _____

GROUP FOURTEEN:

___ Unable to relax
___ Water loss/dry mouth or eyes
___ Unable to concentrate or poor memory
___ History of speech impediment
___ Muscle weakness
___ Easily startled
___ Loss of energy and fatigue
___ Frequent sore throat

TOTAL _____

GROUP FIFTEEN:

___ Dry skin or eruptions
___ Tremors
___ Frequent mouth sores
___ Inability to control blood pressure
___ Inability to conceive or induce labor
___ Hair loss
___ Stiffness after sitting

TOTAL _____