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| Health Questionnaire |  |
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| Completing the questionnaire enables our staff to determine the health issues you face so we can make recommendations for your wellness plan. Answers remain in a secure closed system. | Date |  |  |  |  |  |
|  | MM |  | DD |  | YY |
| Name |  | Date of Birth (DOB) |

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| *We will need to gather some history on your health to determine program plan for you. Please answer yes or no and then expand current symptoms or details that give an accurate description of your current conditions as it relates to body systems and components. Try to write legibly or we can write it for you if that will help.*  |
| **Question and Body System Category** | **Yes / No** | **Use space to explain or provide details relative to question. Provide frequency of pain or the recurring symptoms.** |
| Describe your overall health and what you are looking to accomplish. Physical health or wellbeing or both? Please explain. |  |  |
| **Cardiovascular System:** Do you have heart or circulatory issues? |  |  |
| Have you had heart surgery? If yes, what type of heart surgery did you have? |  |  |
| Do you have an ICD from surgery? If yes, explain. |  |  |
| Do you have high blood pressure? If yes, is it being treated/explain. What medication or remedy? |  |  |
| Have you had a stroke? If yes, explain. |  |  |
| Do you get panic attacks? Explain. Do they occur at a particular time of day or event of the day? |  |  |
| Do you have regular chest pain?  |  |  |
| Do you extremities shake or feel pain?  |  |  |
| Do you have circulatory issues like nerve or extremity pain? Or Neuropathy? |  |  |
| Are there specific heart or vascular issues you are targeting to be healed from? |  |  |
| Do you have high cholesterol? What is it normally? Are you bring treated with medication and what is the medication and dosage? |  |  |
| **Respiratory System:** Do you have a hard time breathing normally or when walking at a slow pace?  |  |  |
| Have you had any surgeries on your lungs? If yes, describe the surgery(ies) you had. |  |  |
| **Immune System:** Do you get flus or colds often? |  |  |
| How long do your flus or colds last? Have you seen an increase in duration in the last five years, ten years? |  |  |
| Have you had the Covid vaccine and any boosters? Or any other vaccines over the last 10 years? |  |  |
| **Digestive System:** Do you have any digestive issues/illnesses you are targeting to be healed from? |  |  |
| Do you notice or have any skin issues like rashes, bumps, itching or any other issue on the skin or directly under the skin.  |  |  |
| How many hours of sleep do you get each night? |  |  |
| Do you experience headaches? If so, how often. Explain. |  |  |
| What is your blood type? |  |  |
| Do you have problems with having a short fuse? Do daily issues stress you to the point, you notice a change in your body or behavior? Think about this. No right or wrong answer, just an observation. |  |  |
| Have you lost or gained weight recently? If so, is there a physical or mental reason in your opinion?  |  |  |
| Is stress hard to manage on a daily basis? No right or wrong answer, just observe the question and think about your daily living in response.  |  |  |
| Do you go to the bathroom normally. Explain if the answer is no.  |  |  |
| **Excretory Systems:** Do you have issues in your kidneys or liver? Or get UTIs? If yes, explain. |  |  |
| Have you had kidney failure or disease? Explain. |  |  |
| Have you had liver disease or surgeries? Explain with date it started and is it resolved? |  |  |
| Do you have pain in your kidney or liver? When did it start and explain the condition.  |  |  |
| Goals: Are there specific kidney, liver or waste issues you want to be healed from? Explain. |  |  |
| **Endocrine Systems:** Do you have issues with hormones, regulating metabolism, reproduction, thyroid, adrenal or other systems in the Endocrine System. If yes, explain in more detail. |  |  |
| Do you have a thyroid condition? If so, what type. Explain. |  |  |
| Do you suffer from one or more autoimmune diseases? Describe the details here of your symptoms? |  |  |
| Have you been diagnosed with a Thyroid condition? If so, explain. |  |  |
| **Reproductive Systems:** Do you have difficulty with the reproductive system in male or female? Explain. **Skip this section if doesn’t apply.** |  |  |
| Do you have a lot of ovulatory pain each month? Describe.  |  |  |
| Do you have a hard time getting pregnant?  |  |  |
| Have you had an issue with miscarriages? Explain. |  |  |
| **Food Habits & Lifestyle.** What does your diet look like daily. Describe the food you eat for meals, the frequency of meals, the food between meals and the beverages you drink on a routine basis. Use this guide to make it clear. We are looking for a description of your breakfast food and beverage, morning snack, lunch food and beverage, pm snack, dinner food and beverage and evening food or beverage. If you don’t eat 3 meals or snacks, then just write what you do each and drink. Include the number of vegetables and fruit, meat, and other food choices throughout the day. |  |  |
| Do you drink tap water, bottled water or do you have a water filtration system? How much pure water do you drink a day? Explain if needed. |  |  |
| Do you eat foods with refined sugar routinely? Name the common foods you eat. |  |  |
| Do you eat most grocer meats or pasture fed and finished meats? Explain if needed. |  |  |
| Do you eat organic or regular fruits and vegetables? Explain if needed. |  |  |
| Do you drink alcohol or beer? If so, how many days a week and how much in a day. Explain if needed.  |  |  |
| Do you exercise regularly? If so, what is your schedule?  |  |  |
| Have you been diagnosed with a chronic illness? Explain. If yes, date diagnosed. And define your daily symptoms. |  |  |
| Do you take medication on a routine basis? If so, what do you take, your dosage and what are you treating? Do you experience side effects from the medication(s) you take? |  |  |
| Do you take supplements? If so, what are they? |  |  |
| Has the medication improved your health? Or made it worse. Explain.  |  |  |
| Are you under the care of a physician now with specific instructions or protocols? Explain. |  |  |
| If you have more than one doctor, are you able to conference or coordinate your treatments among them to ensure you are not over medicated or seeing any contraindications? Explain. |  |  |
| Are you obese meaning 20% over your ideal average weight? How long? |  |  |
| Do you have back pain? How long and where. Explain. |  |  |
| Do you or have you had a hernia? Have you had surgery for it? Explain.  |  |  |
| Do you have Diabetes? |  |  |
| Do you have any known food sensitivities? |  |  |
| Describe stress in your life? How do you manage it? |  |  |
| Do you struggle with being happy? |  |  |
| Do you have a spiritual practice that helps? Marigold Healing is a faith-based ministry that uses holistic solutions to bring the right environment for the body to heal. We do not evangelize our clients but focus on the power of the body, mind and spirit to heal. We are happy to answer any questions.  |  |  |
| Would you be willing to learn about ancient practices that help the body to move energy and bring healing to the body at the cellular level? |  |  |
| Is there any other issues you want to note for us to know in your overall health and wellbeing plan? |  |  |
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**Acknowledge Terms**

By completing and submitting this form and providing your electronic signature or written signature, you acknowledge and agree to this Disclaimer as well as our Policies, Procedures and Fees; Privacy Policy and Terms of Service should you decide to move forward with membership.

**DISCLAIMER**

* The advice and opinions provided by Michelle Williams and the Marigold Staff are based on their experiences, education, training and experience in helping others. Marigold Healing Center expressly disclaims all responsibility for any liability, loss, claim, damage or risk, personal or otherwise, which may be incurred as a result of any recommendation for any program plan, dietary or lifestyle change, energetic healings, special events, workshops and technologies. Marigold services are not intended as medical advice, nor should it be used as a substitute for medical care administered by a physician or other licensed health care provider.
* Marigold Healing Center and the client have the right to terminate the consulting relationship at any time. It may be necessary to touch the client when fitting to technologies or peripherals for a treatment. Our methodology and practices have not been evaluated by the Food and Drug Administration. Our program and the individual advising services provided are not intended to diagnose, treat, cure, or prevent any disease. Before making any complex health-related decisions, please consult your physician or other licensed healthcare provider.
* We are committed to maintaining client confidentiality and protecting the security of personal information you provide to us by following industry best practices for internet security. We are not required to and currently do not operate under federal Health Insurance Portability and Accountability Act (HIPAA) compliance standards.
* We do not accept insurance but do accept a HSA/FLEX payment for services. We require 2 business days to cancel an appointment, and appointments are paid for in advance. We do not offer refunds, but can reschedule appointments 2 days prior to the booking.

Client Name in Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_