MESOZO
Health & Wellness. LLC.
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MeSozo Health & Wellness Health Questionnaire is designed to help evaluate the client's spiritual, mental and physiological requirements, while organizing an individualized natural health program. These forms must be completed prior to your initial appointment.

First Name: ______________________ Last Name: ___________________________

Male/Female

Mark one choice:

○ Male ○ Female

Street Address

____

City, State, Zip Code
____

Country: ____

Telephone # ( ) _______________ Cell # ( )______________________

Married/Single/Divorced______________________

If married, give spouse's name and address and phone number if different from above

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If unmarried give a personal contact/address/phone number _

Referred by:____

Height (feet', inches")/ Weight (pounds)

____

Vitals /Blood Pressure: Right Arm :

Left Arm: ____

Eye Color

○ Brown ○ Blue ○ Other

Resting Pulse ______________ (bpm)

Basal Temperature __________ (F)

Urine pH: ___________

Saliva pH: ___________

Medications Currently Taking ____

____

____

____

Daily bowels Movements?

◯ 0-1 ◯ 2 ◯ 3 ◯ 4

Do you currently take Supplements or Herbal-Botanicals. Please list individually.

____
____
____
____
____

What do you hope to gain from your consultation?____
____
____
____

Genetic/Family Health History
Mother, Father, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather, Sister/Brother: ____
____
____
____

Previous Surgical Procedures (major or minor along with the year) ____
____
____

Glandulars may be recommended for certain endocrine stimulation. Please select a preference for recommendations:

◯ Preferred ◯ Not Preferred

Glandular Systems -Thyroid/Para-Thyroid

Experience cold hands or feet currently or ever:

◯ Yes ◯ No

Frequently cold/difficulty staying warm:

◯ Yes ◯ No

Cold/but burning sensation within:

○ Yes ○ No

Easy to gain or lose weight:

○ Yes ○ No

Easy to gain or lose weight:

○ Yes ○ No

Irregular heartbeat/Arrythmia's :

○ Yes ○ No

Experience Migraines or Headaches:

○ Yes ○ No

Easily Irritated or Irritable:

○ Yes ○ No

Overweight:

○ Yes ○ No

Low Energy/Frequently tired :

○ Yes ○ No

Have you ever been told you had a Goiter, Hashimoto's, Graves, Riedel's Disease (circle all that apply) :

○ Yes ○ No

Have you or an immediate family had a history of Goiter, Hashimoto's, Graves or Riedel disease

Disease (circle all that apply) :

○ Yes ○ No

Do you sweat profusely or rarely explain:

○ Yes ○ No

Fingernails ridged, brittle or weak:

○ Yes ○ No

Spider or Varicose veins:

◌ Yes ◌ No

Hemorrhoids/Prolapses :

◌ Yes ◌ No

Muscle Cramping/ Legs Tire Easily :

◌ Yes ◌ No

Weakness/Strength in Bladder/ Few Leaks
(circle all that apply above) :

◌ Yes ◌ No

Hernia:

◌ Yes ◌ No

Aneurysm/ Low Bone Density/ Low Calcium
(circle all that apply above and explain) ____
____

Osteoporosis :

◌ Yes ◌ No

Have you ever been told by a Chiropractor that you have Scoliosis/Kyphosis/Lordosis
(circle all that apply above) :

◌ Yes ◌ No

Symptoms of Depression, PTSD, OCD, etc. if so explain:
____
____
____
____

Do you have continued spine concerns, deterioration, pain, bone spurs or herniated discs:

____
____
____
____

Glandular System Endocrine/Exocrine -Pancreas

Food Digests Quickly (Diarrhea):

○ Yes ○ No

Acid Reflux/Heartburn/Indigestion
(circle all that apply above) :

○ Yes ○ No

Undigested Food in Stool:

○ Yes ○ No

Thin/Difficult to Weight Gain:

○ Yes ○ No

Moles/Skin Tags:

○ Yes ○ No

Glandular System -Adrenal Glands

Have you ever been diagnosed with MS, ALS, Parkinson's or Palsy
(circle all that apply above):

○ Yes ○ No

Anxiety:

○ Yes ◉ No

Are anxiety attacks and feelings of being overly anxious a daily experience, if so explain:

____
____
____
____

Do you experience Excessive Shyness/Inferiority Complex:

◯ Yes ◯ No

Tremors/Nervous Legs:

◯ Yes ◯ No

High or Low Blood Pressure (circle all that apply):

◯ Yes ◯ No

Hypoglycemia (Low Blood Sugar) :

◯ Yes ◯ No

Diabetes Type 1 / Type 2
(circle all that apply above) :

◯ Yes ◯ No

Tinnitus (Ears Ringing) :

◯ Yes ◯ No

Difficulty Taking Deep Breath/ Short of Breath
(Circle all that apply above) :

◯ Yes ◯ No

Cardiac Arrythmia/Please explain :____

____

◯ Yes ◯ No

Sleep Hindrance: Difficulty Getting to Sleep or Staying Asleep/Please explain:

____

____

◯ Yes ◯ No

Chronic Fatigue Syndrome (CFS):

◯ Yes ◯ No

Addison's Disease/ Congenital Adrenal Hyperplasia (Circle all that apply above) :

Yes No

High Cholesterol:

Yes No

Do you have any current "itis" Condition (Arthritis, Osteoarthritis, Bursitis, etc. Please list and explain: ____
____
____

Yes No

Low Steroids/Low Cortisol :

Yes No

Are You Experiencing Any Lower Back Weaknesses :

Yes No

Female Reproductive/Female Only

Are you Currently Breastfeeding :

Yes No

Do You Have Irregular Menstruations :

Yes No

Does excessive bleeding occur during menstruation:

Yes No

Do you experience Sore or Painful Breasts, esp. During Menstruation :

Yes No

Low or Excessive Sex Drive :

Yes No

Have you ever had fibromyalgia or scleroderma:

Yes No

Do you have excessive or low sex drive (please explain) :____
____
____

◯ Yes ◯ No

Have you had a hysterectomy, if so, explain whether full or partial and the date:

◯ Yes ◯ No

Were any other Organs removed/Lymph nodes during your hysterectomy, (i.e. gallbladder) if so explain:____
____
____

◯ Yes ◯ No

Conceiving a Difficult Area:

◯ Yes ◯ No

Birth Control Pills: List How Long: ______________________________

◯ Yes ◯ No

Male Reproductive /Male Only

Ever diagnosed with Prostatitis :

◯ Yes ◯ No

Frequent Urination :

◯ Yes ◯ No

Diagnosis of Prostate Cancer:

◯ Yes ◯ No

PSA levels test (if so list here) :

◯ Yes ◯ No

Hypertrophy in the Testicals (Enlarged) :

◯ Yes ◯ No

Sex Drive Low/Excessive :

- ○ Yes
- ○ No

Erection Problems :

- ○ Yes
- ○ No

Premature Ejaculation:

- ○ Yes
- ○ No