Consultation Form

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www.genomicshealth360.com

Please fill this form. We protect your privacy and maintain confidentiality in accordance with local and federal guidelines and regulations.

Name _____ DOB _____

Phone (Mobile) _____ Email Address _____

Address _____ City _____

State _____ Zip _____ How did you hear about us? _____

Occupation _____

For Women: Are you pregnant? ❒ Yes ❒ No

Blood Sugar ☐ Blood Pressure ☐ Cholesterol ☐ Liver ☐ Heart ☐
Kidney ☐ Urinary Infection ☐ Thyroid ☐ Skin Problems ☐
Arthritis ☐ Depression ☐ Stress ☐ Metabolism ☐
Allergies ☐ Food ☐ _____ Seasonal ☐ _____

Pains: Joints ☐ Kness ☐ Arms ☐ Legs ☐ Shoulders ☐ Back ☐

Belly Pain – R ☐ L ☐ C ☐

Constipation ☐ Acid ☐ Ht. Burn ☐ Gas ☐
Asthama ☐ Nasal Blockage ☐ Congestion ☐ PND ☐
Throat Itchy ☐ Dry Throat ☐ Eye/Ear itchy ☐ Sleep ☐
Numbness ☐ Neck Stiff ☐ Hand & Feet Cold ☐ Hair fall ☐
Heat from Body ☐ SOB ☐ Energy Low ☐ Inflammation ☐
Palpitation ☐ Weight Loss ☐ Weight Gain ☐
Concentration ☐ Memory ☐ Head ache/Migraines ☐
Vision-Reading ☐ Driving ☐

List of Current Medication s: _____

Any other health conditions not listed above? Please add below.

_____

Which of the above is the worst?

_____

How long have you been suffering or struggling with this condition?

_____

How often does it occur? (daily, weekly, monthly?)

_____

What is your pain on a scale of (1=mild, 10=severe)? _____

What have you tried that did not help? _____

How do you see your life in 3 years if the problem/s will get worse?

_____

How would your life be if this/these problem/s will improve or resolve?

_____

Does this cause you to suffer from?

- ❒ Irritability or anger
- ❒ Interrupted sleep
- ❒ Restricted daily activity
- ❒ Feeling frustrated or experience mood disorder
- ❒ Fatigue
- ❒ Decline in physical activity

Does this affect your life?

- ❒ Holds me back from enjoying my family or friends
- ❒ Affects my ability to work (or provide income)
- ❒ Restricts my productivity or household duties
- ❒ Prevents me from exercising or practicing sports
- ❒ Interferes with my ability to enjoy my hobbies

I understand the purpose of the consultation is to better understand my health concerns. I understand that this consultation is not a medical evaluation or treatment and does not establish a provider-patient relationship.

Name _____ Date _____

Signature _____