PATIENT INFORMATION:

Date:_____

Name:_____ Date of Birth:_____ Age: _____

Address (Street, City, Zip):_____

Parent 1 Phone: (cell)_____ (other)_____ Email: _____

Parent 2 Phone: (cell)_____ (other)_____ Email: _____

Please circle, parents are: married divorced widowed remarried re-partnered in the home

Gender: _____ Preferred Pronouns: _____ Was your child fostered/adopted? _____

How did you learn about our office? _____

Current Physician _____Diagnosis by MD_____

Which of the following types of treatment has your child used before? **Circle all that apply:**

Acupuncture Herbal Medicine Chiropractic Massage Functional Medicine Dietary Consultation Homeopathy

PRIMARY COMPLAINTS:

1.
2.
3.

MEDICAL HISTORY:

MEDICATIONS: Please list all prescribed (allopathic) drugs, non-prescribed medications, vitamins, herbs etc., that your child is taking, stating what they are used for.

1. 4.
2. 5.
3. 6.

Please check: Does your child use or do any of the following on a regular basis?

Exercise	Alcohol	Tobacco	Recreational Drugs	Coffee or Tea	Soft drinks	Sugar	Non-sugar sweeteners	Soy Products	Wheat/ Gluten	Vegetarian/ Vegan diet

Please list any hospitalizations, accidents, and major past illnesses. Include dates and ages.

1.
2.
3.
4.

Please list any serious diseases in your family history such as Cancer, Diabetes, Hypertension, Heart disease, Dementia, etc.

Mother: Father:

Grandparents: Siblings:

Identity

Asian Medicine seeks to understand you as a whole person, in order to provide treatment most tailored to you. Your identity - both from your own perspective and how that affects your experience in life - may be an important component of your health picture. Some aspects of your identity may be obvious to others, while other aspects are known only to you. Please circle any aspects of your/child's identity that you feel may contribute (positively or negatively) to your/their health. We welcome discussion on these areas as they pertain to their well-being.

Age Sex Gender Sexual Orientation Race Ethnicity Religion Disability Neurodivergence
Other _____

Please circle or highlight with colored marker current complaints

General

Spontaneous sweating	Sleep apnea	Premature birth
Excessive sweating	Average # hours of sleep at night ___	Forceps delivery
Night sweats	Fatigue or weakness	Held in an incubator
Lack of sweating	Sudden energy drop: time? _____	Life-threatening event
Hot / Cold intolerance	Palpitations / Awareness of heartbeat	Auto-immune disease
Cold Hands / Feet / All Over	Braces/orthodontia	Immune issues e.g. high ANA titer
Freezing Hands / Feet / All Over	Grinding teeth / TMJ	Infections e.g. HIV+, Lyme, EBV
Hot Hands / Feet / All Over	Dental amalgam fillings	Cancer: Type?
Fevers / Chills	Removal of teeth	Smoking / Vaping / Marijuana
Aversion to hot weather or summer	Swollen glands	Alcohol / Recreational Drugs
Aversion to cold weather or winter	Taste in mouth: Bitter / Metallic / Sweet / Salty / Sticky	Regular exposure to Pollution / Exhaust Fumes / Plastics / Pesticides
Aversion to damp or humid weather	Loss of smell or taste	Poor Indoor quality / Mold exposure
Aversion to wind or fans/air conditioning	Dry: Mouth / Ear / Eye / Nose / Throat	Heavy metal exposure (e.g. Mercury / Lead / Arsenic)
Sleep interrupted due to: Thoughts / Pain / Urination / Other: _____	Lymphedema	Regular exposure to Chemicals / Personal care items
Light sleep	Vertigo / Dizziness	Multiple chemical sensitivities
Difficulty falling asleep	Bleed or bruise easily	Overtraining syndrome
Difficulty staying asleep	Hair loss	Lack of physical exercise
Wake too early	Iron Overload	Current Weight_____lbs
Wake up tired	Diagnosis of hemophilia? Y N	Current Height_____' _____"
Sleep too much	Weight Gain / Loss	Other:
Nightmares	Body mass index (BMI): Low / High	

Musculoskeletal

Pain: Head / Neck / Jaw / Shoulder	Hernia pain; Location:_____	Muscle spasms; Location: _____
Pain: Arm / Elbow / Wrist / Hand	Hypermobile	Leg cramps
Pain: Hip / Leg / Knee /Ankle / Foot	Joint swelling	Muscle atrophy
Pain: Chest / Ribs / Back / Abdomen	Reduced range of motion	Muscle pains
Type of pain: Sharp / Fixed / Dull / Oppressive / Sore / Movable / Tight / Stiff / Radiating / Pricking	Joint cracking / Crepitus of joints	Muscle weakness
	Deformities of bones	Other:
	Brittle bones	

Neurological		
Traumatic head injury – Lost consciousness? Yes No	Weakness of limb, loss of grip strength	Stroke or TIA (Transient ischemic attack)
Severe emotional trauma - PTSD	Uncontrolled, excessive movement / Restless legs	Recent aversion to loud noises or crowds
Areas of numbness, tingling, electric	Paralysis	Inappropriate / Slow speech
Tremors / Tics	Poor Memory / Concentration	Poor word recall
Seizures / Convulsion	Confusion / Brain fog	Increased need for sleep
Lack of coordination / Balance	Cognitive impairment	Fainting
Frequent falls	Poor brain stamina	Fatigue easily with common tasks
Deteriorations with handwriting	Social isolation	Other:

Dermatological		
Eczema	Hives	**Quality of skin:**
Rosacea	Pus or boils	Itching / Redness / Scaling / Oily
Psoriasis	Ulcerations	Cracking / Flaking
Acne	Rash	Dryness / Burning
Fungal infections	Sores; Location: _____	Other:

Cardiovascular		
Blood pressure: High / Low	Fainting	Varicose veins
Heartbeat: Irregular / Rapid / Slow	Atherosclerosis	Blood clots
Swelling of Feet / Hands	High cholesterol levels	Chest pain
Shortness of breath	High triglyceride levels	Other:

Respiratory		
Allergies	Dry cough	Difficulty breathing
Catch colds frequently/easily	Cough with Scanty / Profuse phlegm	Difficulty laying down
Asthma	Coughing up blood	Snoring
Bronchitis	Phlegm Hard / Easy to expectorate	Excessive salivation
Pneumonia	Phlegm color: White / Yellow	Other:

Gastrointestinal		
Appetite: Increased / Decreased	Bad breath	Itchy anus
Bloating / Passing gas	Mouth sores / Burning tongue	Anal fissures
Pain after eating	Painful / Bleeding / Receding gums	Hemorrhoids
Food sits in stomach	Problems swallowing	Diabetes Type 1 or 2
Epigastric fullness after eating	Nausea/ Belching/ Hiccups/ Vomiting	Insulin resistance
Heartburn / Reflux / Indigestion	Hiatal hernia	Gallstones / Hepatitis / Pancreatitis
Upper epigastric pain	Bowel movement frequency:	Parasites
Lower abdominal pain	Constipation	Food Allergies:
Rectal pain	Stool incontinence	Number of meals per day: _____
Pain: Stabbing / Distending / Dull	Forceless bowel movement	Big / Small meals
Not thirsty	Incomplete bowel movement	Snacks only
Thirst for Cold / Warm / Hot liquids	Stools: Formed / Loose / Dry / Sticky / Mucus / Bloody	Prefer Warm/Cooked / Cold/Raw food
Thirst at Night	Difficult bowel movement	Regular/daily smoothie
Drinking causes Nausea/Full/Bloat	Painful bowel movement	Cravings; Type:
Drinking doesn't quench thirst	Liquid stools or diarrhea	Other:

Genito-Urinary		
Urination frequency: Fewer than 4x day / 4-6 x day / Over 6 x day	Profuse urination	Clear urine
	No force to urinate	Genital sores
	Bedwetting / Incontinence	Interstitial cystitis
Nighttime urination frequency:_____	Red / Pink / Cloudy urine	Urinary tract infection
Painful / Difficult / Urgent urination	Dark urine	Edema: where? _____
Interrupted / Hesitant urination	Light yellow urine	Other:
Head, Eyes, Ears, Nose & Throat		
Headaches / Migraines	Pressure in eyes / Ears	Runny nose / Sneezing
Eye pain	Earache	Peculiar smells
Poor / Blurry vision	Tinnitus / Ringing in Ears	Nose bleeding
Poor night vision	Poor hearing / Deafness	Sore throat / Lump in throat
Light sensitivity	Blocked sinuses / Post-nasal drip	Laryngitis / Tonsillitis
Floaters or spots in front of eyes	Nasal polyps / Tonsil stones	Other:
Emotional		
Happy / Content	Easy irritable or angered	Mental health diagnosis: _____
Numb or Flat	Aggressive / Bad temper	Family / Relationship Stress
Sensitive	Low stress tolerance	Work stress
Sad	Worry, over-thinking	Financial stress
Discontent	Mood swings	Lack of stress-coping mechanisms
Emotional / Weepy / Fearful	Suicidal	Lack of community / family support
Disconnected	Depression	Other:
Gynecological		
Age Menses began _____	Date of last PAP: _____	Difficult birth / Caesareans
Cycle length: _____ Days	Pain with intercourse	Thin / Thick endometrium
Days between cycles: _____ Days (e.g. 28 days)	Vaginal discharge: Scanty / Profuse	Endometriosis
Regular / Irregular menstrual cycle	Strong vaginal odor	Fibroids / Adhesions / Cysts
Early / Late menses	Vaginal Pain / Sores / Dryness	Facial hair growth
No periods / Amenorrhea	Pelvic inflammatory disease	Breast soreness
Color of Blood: Red / Pale / Brown / Dark Red / Pink-watery / Purplish	Sexually transmitted infection e.g. HPV / Chlamydia / Other:	Fibrocystic breasts
Scanty / Heavy menstrual bleeding	Method of birth control:	Breast cancer
Clots: Few / Many Large / Small	Number of pregnancies:	Ovarian / Uterine cancer
Menstrual cramps	Number of live births:	Libido Increased / Decreased
Menstrual cramps radiating into legs	Number of abortions:	Hot flashes
Pelvic pain	Number of miscarriages:	Age at menopause:
PMS	Are you pregnant? Yes No	Other:
Andrological		
Undescended Testicle	Penile discharge	
Scrotal Itching / Dampness / Pain	Trouble with erections	
Painful / Swollen testicles	Sexually transmitted infection	
Prostatitis / Epididymitis	Perianal soreness	Cancer:

Anything else you would like us know:

Please describe the general atmosphere in the home (parental dynamics, siblings, activities, etc):

If known, please describe the child's conception (natural? IVF?), pregnancy, and birth:

Was your child vaccinated on schedule? Yes No

Child Neurotransmitter and Nutrition Assessment Form™ (CNNQ)

Child's Name:_____ **Age:** _____ **Sex:** _____ **Date:** _____

SECTION: GENERAL DIET

- Does your child have any food sensitivities or allergies? (If yes, please list)

_____

_____

- List your child's 4 healthiest foods eaten during the average week.

_____

_____

_____

_____

- List your child's 4 unhealthiest foods eaten during the average week.

_____

_____

_____

_____

- How many times does your child eat sugar per week?

_____

- How many times does your child drink soda per week?

_____

- List the top 4 foods your child craves regularly.

_____

_____

_____

_____

- List the medication(s) your child is currently prescribed and any over-the-counter products used (skip if you listed these on page 1).

_____

_____

- Do you find it difficult to have your child on a special diet?

_____

_____

Please circle the appropriate number on all questions below (0 as the least/never to 3 as the most/always).

SECTION A

- Does your child eat pasta, breads, and breaded foods? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after eating foods containing wheat/gluten? **0 1 2 3**
- Does your child consume dairy products? **0 1 2 3**
- Does your child have symptoms (fatigue, hyperactivity, etc) after consuming dairy products? **0 1 2 3**

SECTION B

- Does your child eat fried fish? **0 1 2 3**
- Does your child eat roasted nuts or seeds? **0 1 2 3**
- Is your child missing essential fatty acid-rich foods in his/her diet? (for example: avocados, flax seeds, olives) **0 1 2 3**
  (circle "0" if present, "3" if missing)
- Does your child eat fried foods? **0 1 2 3**

SECTION C

- Is your child's mental speed slow? **0 1 2 3**
- Does your child have difficulty with learning or memory? **0 1 2 3**
- Does your child have difficulty with balance and coordination? **0 1 2 3**

SECTION D

- Does your child have stress? **0 1 2 3**
- Does your child not have enough sleep and rest? **0 1 2 3**
  (circle "0" if enough, "3" if not enough)
- Does your child not have regular exercise? **0 1 2 3**
  (circle "0" if regular exercise, "3" if no exercise)
- Does your child feel overly worried and scared? **0 1 2 3**

SECTION E

- Does your child have temper tantrums? **0 1 2 3**
- Does your child exhibit wild behavior? **0 1 2 3**
- Does your child frequently yell or scream for unnecessary reasons? **0 1 2 3**
- Does your child have an inability to nap or sleep when physically exhausted? (circle "0" if able, "3" if unable) **0 1 2 3**
- Is your child overly talkative? **0 1 2 3**
- Does your child fidget and squirm when seated? **0 1 2 3**
- Does your child run and climb excessively? **0 1 2 3**
- Does your child have difficulty playing quietly or engaging in leisure activities? **0 1 2 3**

SECTION F

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiety and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when he/she is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION G

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep, restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION H

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after many hours of sleep? 0 1 2 3
- Does your child tend to isolate himself/herself from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have a constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION I

- Does your child have difficulty with visual memory (shapes and images)? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or a short attention span? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movements? 0 1 2 3

Consent Form, Office Policies, HIPAA Privacy Policy, Confidentiality, and Email Permissions

After you read our various Office Forms and Policies, please *initial* each item below, and *sign* at bottom of the form.

1. _____ I acknowledge that I was shown and have read a copy of the Consent Form from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

2. _____ I acknowledge that I was shown and have read a copy of the Office Policies from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

3. _____ I acknowledge that I was shown and have read a copy of the HIPAA Privacy Policy from Meridian Health Solutions, LLC (MHS). If I want a copy for myself, I can access one from the MHS website under Forms, or be given a copy in the office.

4. _____ Confidentiality and Virtual Assistants: I acknowledge that Virtual Assistants such as Siri, Alexa, and Google Assistant are not confidential nor HIPAA-compliant. Thus, my confidentiality may be compromised by the presence of my own or other peoples' cell phones in the MHS office. I will minimize the problem by putting my cell phone in Airplane mode, turning it off, or disabling the virtual assistant before entering the treatment area.

5. Email and Texting Permission: MHS does not operate on a secure email or text platform, but we use email and text for ease and convenience. If you want to communicate with us via email and/or text, check the specific boxes below for which you provide consent. You may opt out at any time. MSG + data rates may apply.

   ___ I authorize MHS to use scheduling software that sends me automatic scheduling emails and/or texts.

   ___ I authorize MHS to text me regarding scheduling and non-medical communication.

   ___ I authorize MHS to email me regarding my medical care and questions.

   ___ I authorize MHS to email me periodic announcements such as the annual olive oil sale or clinic news updates (we do not bombard you; we send about 6 mass emails per year).

   I wish to receive communication at the following:

_____ _____
Email address Phone number

_____ _____
Patient's Full Name (please print) Signature of Patient or Responsible Party/Guardian

_____
Date