PATIENT INFORMATION: Date:_____

Name:_____ Date of Birth:_____ Age: _____

Address (Street, City, Zip):_____

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

Gender: _____ Preferred Pronouns: _____

Circle One: single partnered married polyamorous separated divorced widowed other: _____

Occupation: _____Name of Spouse/Partner or Parent (if child): _____

Emergency contact (name): _____ (phone): _____

How did you learn about our office? _____

Current Physician _____Diagnosis by MD_____

Which of the following types of treatment have you experienced 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 you are taking, stating what they are used for.

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

Please check: Do you 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 identity that you feel may contribute (positively or negatively) to your health. We welcome discussion on these areas as they pertain to your 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		
Benign prostate enlargement	Erectile dysfunction / Impotence	Penile discharge
Scrotal Itching / Dampness / Pain	Soft erections	Sexually transmitted infection
Painful / Swollen testicles	Morning Erections? Yes No	Perianal soreness
Prostatitis / Epididymitis	Libido: Increased / Decreased	Cancer: Testicular / Prostate
Undescended Testicle	Premature Ejaculation	Other:

Female Infertility Issues

How long have you tried to conceive?	Endometritis (Bacteria / Chlamydia / Gonorrhea / other infection)	Use or used hormones e.g. birth control pill, progesterone IUD, HRT?
Diagnostic imaging performed	Endometrial polyps	# of IUI cycles:
Family history of infertility	Cervical stenosis (narrowing)	# of IVF cycles: _____
Age mother went into menopause:	Thickened cervical mucous	Low progesterone
Day 3 FSH level:	Polycystic ovarian syndrome (PCOS)	Luteal phase problems
AMH level:	Milky discharge from nipples	Other:

Male Infertility Issues

How long have you tried to conceive?	Penis birth defects / Anatomical abnormalities	Retrograde ejaculation
Diagnostic imaging performed	Hypogonadism: Primary / Secondary	Ejaculatory duct blockade
Family history of infertility	Sertoli cell dysfunction	History of pelvic surgery
Normal sperm analysis: Yes No	Testicular infection	Varicocele
Low sperm motility	Undescended testicles	Other:
Low sperm count	Anti-sperm antibodies	

Thank you for answering the questions below. We know it's a lot! Some of the questions may seem redundant, but they help us to understand your patterns. You spending time on this now will translate to better treatment results!
Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

SECTION 1 – GenB					Do you have difficulty calculating numbers?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are names or phone numbers hard time remember?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
Do you have a hard time remembering your appointments?	0	1	2	3	**SECTION 4 - D**				
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
Are you losing your attention span endurance? 0.15"	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	Do you have anger and aggression while under stress?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	Are not feeling rested even after long hours of sleep?	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	Do you have unexplained lack of concern for family & friends?	0	1	2	3
SECTION 2 – S					How easily are you distracted from your tasks?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Do you feel the need to consume caffeine to stay alert?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you feel sad or down for no reason?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel like you are **not** enjoying life?	0	1	2	3	**SECTION 5 – G**				
How often do you feel you lack artistic appreciation?	0	1	2	3	How often do you feel anxious of panic for no reason?	0	1	2	3
How often do you feel depressed in overcast weather?	0	1	2	3	Do you have feelings of dread or impending doom?	0	1	2	3
Are you losing your enthusiasm for your favorite activities?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How much are you losing enjoyment for your favorite foods?	0	1	2	3	Do you have feelings of being overwhelmed for no reason?	0	1	2	3
Are you losing enjoyment of friendships and relationships?	0	1	2	3	Do you have feelings of guilt about everyday decisions?	0	1	2	3
Do you have difficulty falling into deep restful sleep?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you have feelings of dependency on others?	0	1	2	3	Is it difficult to turn you mind off when you want to relax?	0	1	2	3
How often do you feel more susceptible to pain?	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
SECTION 3 - ACH					Do you worry about things you didn't worry about before?	0	1	2	3
Has your visual memory (shapes & images) is decreased?	0	1	2	3	Do you have feelings of inner tension inner excitability?	0	1	2	3
Do you feel your verbal memory is decreased?	0	1	2	3					
Do you have memory lapses?	0	1	2	3					
Has your creativity been decreased?	0	1	2	3					
Has your comprehension been diminished?	0	1	2	3					

These next questions help us further prioritize when and where to focus your treatment.

Please circle appropriate number: 0=never/least, 1=occasionally, 2=frequent, 3=all the time

Category I - LI					**Category VII - SI**				
Feeling that bowels do not empty completely	0	1	2	3	Decreased gastrointestinal motility, constipation	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3	Abd distension after certain probiotic or natural supplement	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3	Decreased gastrointestinal motility, constipation	0	1	2	3
Diarrhea	0	1	2	3	Increased gastrointestinal motility, diarrhea	0	1	2	3
Constipation	0	1	2	3	Alternating constipation and diarrhea	0	1	2	3
Hard, dry or small stool	0	1	2	3	Suspicion of nutritional malabsorption	0	1	2	3
Coated tongue or “fuzzy” debris on tongue	0	1	2	3	Frequent use of antacid medication	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3	Diagnosis of Celiac Disease, IBS, Leaky Gut, Diverticulitis	0	1	2	3
More than 3 bowel movements daily	0	1	2	3	Abd distention after consumption of fiber, starches, sugar	0	1	2	3
Use laxatives frequently	0	1	2	3					
					Category VIII - GB	0	1	2	3
Category II - Int Integrity					Greasy or high-fat foods cause distress	0	1	2	3
Increasing frequency of food reactions	0	1	2	3	Lower bowel gas and/or bloating a few hours after eating	0	1	2	3
Unpredictable food reactions	0	1	2	3	Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Aches, pains and swelling throughout the body	0	1	2	3	Burpy, fishy taste after consuming fish oils	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3	Unexplained itchy skin	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3	Yellowish cast to eyes	0	1	2	3
					Stool color alternates from clay colored to brown	0	1	2	3
Category III - Chemical Tolerance					Reddened skin, especially palms	0	1	2	3
Intolerance to smells	0	1	2	3	Dry or flaky skin and/or hair	0	1	2	3
Intolerance to jewelry	0	1	2	3	History of gallbladder attacks or stones	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3	Have you had your gallbladder removed?	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3					
Constant skin outbreaks	0	1	2	3	**Category IX – Hep Detox**	0	1	2	3
					Acne and unhealthy skin	0	1	2	3
Category IV – LHCL					Excessive hair loss				
Excessive belching, burping or bloating	0	1	2	3	Overall sense of bloating				
Gas immediately following a meal	0	1	2	3	Bodily swelling for no reason	0	1	2	3
Offensive breath	0	1	2	3	Hormone imbalances	0	1	2	3
Difficult bowel movements	0	1	2	3	Weight gain	0	1	2	3
Sense of fullness during and after meals	0	1	2	3	Poor bowel function	0	1	2	3
Difficulty digesting proteins/meats, undigested food in stool	0	1	2	3	Excessively foul-smelling sweat	0	1	2	3
Category V - HHCL					**Category X - RHG**	0	1	2	3
Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3	Crave sweets during the day	0	1	2	3
Use of antacids	0	1	2	3	Irritable if meals are missed	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3	Eating relieves fatigue	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3	Feel shaky, jittery or have tremors	0	1	2	3
Temporary relief with antacids, food, milk, carbonated bevs	0	1	2	3	Depend on coffee to keep going/get started	0	1	2	3
Digestive problems subside w/rest and relaxation	0	1	2	3	Get light headed of meals are missed	0	1	2	3
Heartburn from spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3	Agitated, easily upset, nervous	0	1	2	3
					Poor memory or forgetful between meals	0	1	2	3
Category VI - Pan					Blurred vision	0	1	2	3
Difficulty digesting roughage & fiber	0	1	2	3					
Indigestion and fullness last 2-4 hours after eating	0	1	2	3	**Category XI - IR**				
Pain, tenderness, soreness on left side under rib cage	0	1	2	3	Fatigue after meals	0	1	2	3
Excessive passage of gas	0	1	2	3	Craves sweets during the day	0	1	2	3
Nausea and or vomiting	0	1	2	3	Eating sweets does not relieve cravings for sugar	0	1	2	3
Stool undigested, foul smelling, mucus, greasy, poorly formed	0	1	2	3	Must have sweets after meals	0	1	2	3
Frequent loss of appetite	0	1	2	3	Waist girth is equal or larger than hip girth	0	1	2	3
					Frequent urination	0	1	2	3
					Increased thirst and appetite	0	1	2	3
					Difficulty losing weight	0	1	2	3

Category XII - LAdr					**Category XV - LThy**				
Can't stay asleep	0	1	2	3	Tired/sluggish	0	1	2	3
Craves salt	0	1	2	3	Feel cold – hands/feet/all over	0	1	2	3
Slow starter in the morning	0	1	2	3	Require excessive amounts of sleep to function properly	0	1	2	3
Afternoon fatigue	0	1	2	3	Increase in weight even with low calorie diet	0	1	2	3
Dizziness when standing up quickly	0	1	2	3	Gain weight easily	0	1	2	3
Afternoon headaches	0	1	2	3	Difficult, infrequent bowel movements	0	1	2	3
Headaches with exertion or stress	0	1	2	3	Depression/lack of motivation	0	1	2	3
Weak nails	0	1	2	3	Morning headaches that wear off as the day progresses	0	1	2	3
					Outer third of eyebrows thinning	0	1	2	3
Category XIII - HAdr	0	1	2	3	Thinning hair: scalp, face, genitals or excessive hair loss	0	1	2	3
Cannot fall asleep	0	1	2	3	Dry skin and/or scalp	0	1	2	3
Perspire easily	0	1	2	3	Mental sluggishness	0	1	2	3
Under a high amount of stress	0	1	2	3					
Weight gain when under stress	0	1	2	3	**Category XVI - HThy**				
Wake up tired even after 6 or more hours of sleep	0	1	2	3	Heart palpitations	0	1	2	3
Excessive perspiration or perspiration w/little or no activity	0	1	2	3	Inward trembling	0	1	2	3
					Increased pulse rate even at rest	0	1	2	3
Category XIV - Elec					Insomnia	0	1	2	3
Edema and swelling in ankles and wrists	0	1	2	3	Nervous and emotional	0	1	2	3
Muscle cramping	0	1	2	3	Night sweats	0	1	2	3
Poor muscle endurance	0	1	2	3	Difficulty gaining weight	0	1	2	3
Frequent urination	0	1	2	3					
Frequent thirst	0	1	2	3					
Crave salt	0	1	2	3					
Abnormal sweating from minimal activity	0	1	2	3					
Alteration in bowel regularity	0	1	2	3					
Inability to hold breath for long periods	0	1	2	3					
Shallow, rapid breathing	0	1	2	3					

Anything else you would like us know:

Signatures for
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