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, hormone replacement therapy
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	

Anything else you would like us know:

_____

_____

_____

_____

_____

Health Questionnaire

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

SECTION - A	0	1	2	3	How often do you feel you lack artistic appreciation?	0	1	2	3
Is your memory noticeably declining?	0	1	2	3	How often do you feel depressed in overcast weather?	0	1	2	3
Are you having a hard time remembering names and phone numbers?	0	1	2	3	How much are you losing your enthusiasm for your favorite activities?	0	1	2	3
Is your ability to focus noticeably declining?	0	1	2	3	How much are you losing enjoyment for your favorite foods?	0	1	2	3
Has it become harder for you to learn things?	0	1	2	3	How much are you losing enjoyment of friendships and relationships?	0	1	2	3
How often do you have a hard time remembering yourappointments?	0	1	2	3	How often do you have difficulty falling into deep restful sleep?	0	1	2	3
Is your temperament getting worse in general?	0	1	2	3	How often do you have feelings of dependency on others?	0	1	2	3
Are you losing your attention span endurance?	0	1	2	3	How often do you feel more susceptible to pain?	0	1	2	3
How often do you find yourself down or sad?	0	1	2	3	How often do you have feelings of unprovoked anger?	0	1	2	3
How often do you fatigue when driving compared to the past?	0	1	2	3	How much are you losing interest in life?	0	1	2	3
How often do you fatigue when reading compared to the past?	0	1	2	3	**SECTION 2 - D**	0	1	2	3
How often do you walk into rooms and forget why?	0	1	2	3	How often do you have feelings of hopelessness?	0	1	2	3
How often do you pick up your cell phone and forget why?	0	1	2	3	How often do you have self-destructive thoughts?	0	1	2	3
SECTION - B	0	1	2	3	How often do you have an inability to handle stress?	0	1	2	3
How high is your stress level?	0	1	2	3	How often do you have anger and aggression while under stress?	0	1	2	3
How often do you feel that you have something that must be done?	0	1	2	3	How often do you feel you are not rested even after long hours of sleep?	0	1	2	3
Do you feel you never have time for yourself?	0	1	2	3	How often do you prefer to isolate yourself from others?	0	1	2	3
How often do you feel you are not getting enough sleep or rest?	0	1	2	3	How often do you have unexplained lack of concern for family and friends?	0	1	2	3
Do you find it difficult to get regular exercise?	0	1	2	3	How easily are you distracted from your tasks?	0	1	2	3
Do you feel uncared for by the people in your life?	0	1	2	3	How often do you have an inability to finish tasks?	0	1	2	3
Do you feel you are not accomplishing your life's purpose?	0	1	2	3	How often do you feel the need to consume caffeine to stay alert?	0	1	2	3
Is sharing your problems with someone difficult for you?	0	1	2	3	How often do you feel your libido has been decreased?	0	1	2	3
SECTION C1	0	1	2	3	How often do you lose your temper for minor reasons?	0	1	2	3
How often do you get irritable, shaky, or have lightheadedness between meals?	0	1	2	3	How often do you have feelings of worthlessness?	0	1	2	3
How often do you feel energized after eating?	0	1	2	3	**SECTION 3 – G**	0	1	2	3
How often do you have difficulty eating large meals in the morning?	0	1	2	3	How often do you feel anxious of panic for no reason?	0	1	2	3
How often does your energy level drop in the afternoon?	0	1	2	3	How often do you have feelings of dread or impending doom?	0	1	2	3
How often do you crave sugar and sweets in the afternoon?	0	1	2	3	How often do you feel knots in your stomach?	0	1	2	3
How often do you wake up in the middle of the night?	0	1	2	3	How often do you have feelings of being overwhelmed for no reason?	0	1	2	3
How often do you have difficulty concentrating before eating?	0	1	2	3	How often do you have feelings of guilt about everyday decisions?	0	1	2	3
How often do you depend on coffee to keep yourself going?	0	1	2	3	How often does your mind feel restless?	0	1	2	3
How often do you feel agitated, easily upset, and nervous between meals?	0	1	2	3	How difficult is it to turn you mind off when you want to relax?	0	1	2	3
SECTION - C2	0	1	2	3	How often do you have disorganized attention?	0	1	2	3
Do you get fatigued after meals?	0	1	2	3	How often do you worry about things you were not worried about before?	0	1	2	3
Do you crave sugar and sweets after meals?	0	1	2	3	How often do you have feelings of inner tension and inner excitability?	0	1	2	3
Do you feel you need stimulants such as coffee after meals?	0	1	2	3	**SECTION 4 - ACH**	0	1	2	3
Do you have difficulty losing weight?	0	1	2	3	Do you feel your visual memory (shapes & images) is decreased?	0	1	2	3
How much larger is your waist girth compared to your hip girth?	0	1	2	3	Do you feel your verbal memory is decreased?	0	1	2	3
Do you suffer from frequent urination?	0	1	2	3	Do you have memory lapses?	0	1	2	3
Have your thirst and appetite been increased?	0	1	2	3	Has your creativity been decreased?	0	1	2	3
Do you experience weight gain when under stress?	0	1	2	3	Has your comprehension been diminished?	0	1	2	3
Do you have difficulty falling asleep?	0	1	2	3	Do you have difficulty calculating numbers?	0	1	2	3
SECTION 1 – S	0	1	2	3	Do you have difficulty recognizing objects & faces?	0	1	2	3
Are you losing your pleasure in hobbies and interests?	0	1	2	3	Do you feel like your opinion about yourself has changed?	0	1	2	3
How often do you feel overwhelmed with ideas to manage?	0	1	2	3	Are you experiencing excessive urination?	0	1	2	3
How often do you have feelings of inner rage (anger)?	0	1	2	3	Are you experiencing slower mental response?	0	1	2	3
How often do you have feelings of paranoia?	0	1	2	3					
How often do you feel sad or down for no reason?	0	1	2	3					
How often do you feel like you are **not** enjoying life?	0	1	2	3					

Meridian Health Solutions Pain Assessment Form Patient ID:_____(office use only)

Which Diagnostic studies have been done to evaluate your pain? (Circle all that apply and bring copies of the reports or films if applicable)

MRI
CT Scan
X-Ray
EMG/Nerve conduction studies
Bone Scan
Blood Tests
Other: _____

Which treatments have been done for your pain? (circle all that apply)

Injection Treatments
Chiropractic
Massage
Physical Therapy
Surgical Procedures: _____
_____
Other: _____

WHERE is your pain? Left/Right sided, or both? _____

WHEN did your pain begin?_____

HOW did your pain begin?_____

What makes your pain WORSE?_____

What makes your pain BETTER?_____

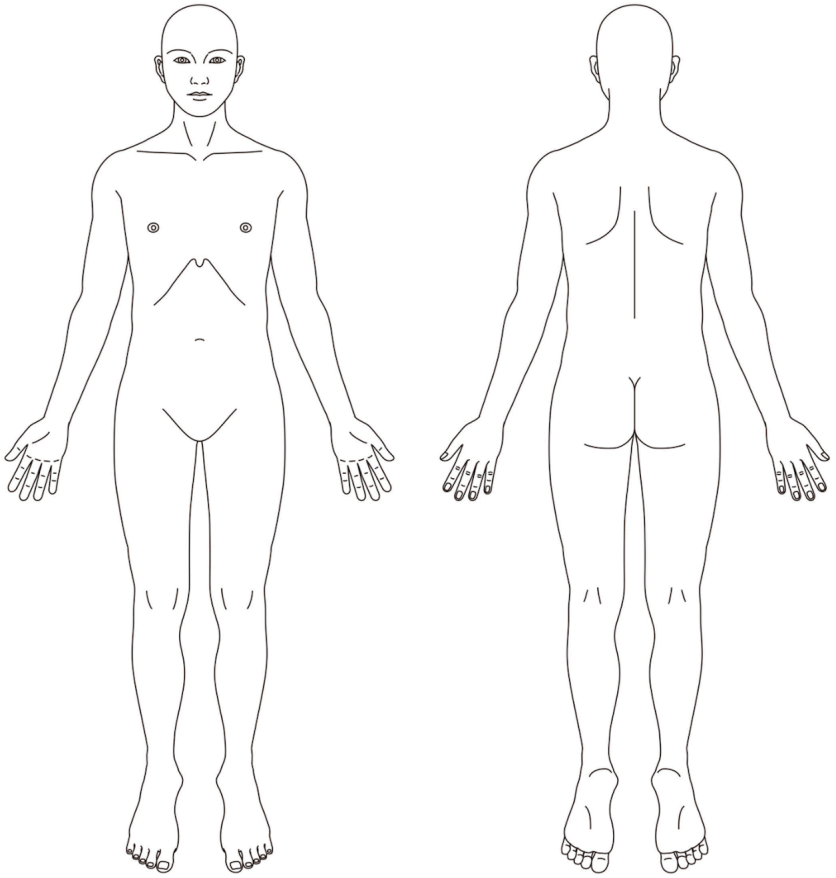
How does the pain affect your daily life?_____

How does your pain CHANGE with time? _____

What does your pain feel like? (circle all that apply)
Warm. Hot. Cold. Sharp. Dull. Burning. Electricity. Stabbing. Tingling. Throbbing. Pounding. Crushing. Pulling. Cramping. Unbearable. Penetrating. Aching. Sore. Heavy. Tender. Blinding. Annoying. Agonizing. Tight. Numb. Squeezing. Other:_____

Circle your areas of pain.
Rate the pain severity 0-10,
10 = highest pain.

Please note anything else you'd like for us to know about your pain:



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