## 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:<br>Fewer than 4x day / 4-6 x day /<br>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 |  | | | | |

## 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 Permission: MHS does not operate on a secure email platform, but we use email for ease and convenience. If you want to communicate with us via email, check the specific boxes below for which you provide consent.

   ☐ I authorize MHS to use scheduling software that sends me automatic scheduling and appointment emails.

   ☐ I authorize MHS staff and/or practitioners to email me with regards to my 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 3 mass emails per year).

   Email Address at which you wish to receive communication:

   _____

_____
Patient's Full Name (please print)

_____
Signature of Patient or Responsible Party/Guardian

_____
Date