# Confidential Patient Information

**The following information is needed in order to better serve you. Please complete all questions to the best of your knowledge. If you need help please ask the receptionist. PLEASE PRINT.**

Name:_____Today's Date:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell phone:_____ Work Phone:_____

Age:_____ D.O.B. :_____ Maritial Status: S M W D

Social Security Number: _____Email:_____

*In Case of Emergency*

Name:_____ ____ Relationship:_____

Home Phone:_____ Cell phone:_____ Work Phone:_____

Employer: _____ Occupation: _____Yrs. On Job:_____

Address:_____City:_____State:_____Zip:_____

Insurance Provider: _____ Member ID #:_____

Plan/Group #: _____ Primary Person Insured: _____
D.O.B. : _____

S.S.N.:_____ Employer Name: _____

Secondary Insurance Provider: _____ Member ID #:_____

Plan/Group #: _____ Primary Person Insured:_____
D.O.B. : _____

S.S.N. :_____ Employer Name: _____

How did you hear about us: TV / Radio / Sign / Friend or Family / Flyer / Other _____

If referred, please tell us who we can thank: _____

**I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.**

**Patient's Signature: _____ Date: _____**

**Spouse or Guardian Signature: _____ Date: _____**

**Notice to New Patients:** Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made prior to seeing the doctor.

# BioMeridian Health Questionnaire

Name: _____ Date: _____

1. Please list all health issues or symptoms you have in order of importance.

| | |
|---|---|
| | |
| | |
| | |
| | |
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| | |

2. Please list all prescription medications you are currently taking.

| Name of Medication | Reason for Medication |
|---|---|
| | |
| | |
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3. List all Vitamins & Supplements you are currently taking.

| | |
|---|---|
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| | |
| | |
| | |
| | |

4. Please list all surgeries you have had and the year they were performed.

| | |
|---|---|
| YR | YR |
| YR | YR |
| YR | YR |
| YR | YR |
| YR | YR |

5. Family History

| | Age | Health Issues &/or cause of death |
|---|---|---|
| Mother | | |
| Father | | |
| Mother's Mother | | |
| Mother's Father | | |
| Father's Mother | | |
| Father's Father | | |
| Brothers | | |
| Sisters | | |
| Children | | |

6. Do you have a pacemaker or implanted device? _____

7. If female, are you pregnant? _____

8. Social History ( check all that apply)

( ) Smoking How many packs/day?
( ) Other Tobacco Use
( ) Alcohol Use How many glasses/day?
( ) Drug Use
( ) Drink coffee/tea How many cups/day?
( ) Diet is: Balanced / Not Balanced
How many meals/day?
( ) Rest is: Sufficient / Not Sufficient
How many hours per night?
( ) Recreation is: Sufficient / Not Sufficient
How many days/wk?
How long is your workout?
( ) My Family Stress is: Severe / Moderate / Minimal / None
( ) How do you like work: I love it / It's OK / I hate it
( ) My Job Stress is: Severe / Moderate / Minimal / None

# SYMPTOM SURVEY

**Patient:** _____ **M / F Date:** _____ **Vegetarian: Y / N**

**INSTRUCTIONS:** ***LEAVE THE QUESTION BLANK*** **if it does not apply to you.**
**CIRCLE (1) for MILD symptoms -occurs once or twice a month**
**CIRCLE (2) for MODERATE symptoms-occurs several time a month**
**CIRCLE (3) for SEVERE symptoms-you are aware of it almost constantly**

## GROUP ONE

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth-eyes-nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up-fail to calm
7. 1 2 3 Cuts Heal Slowly
8. 1 2 3 Gag easily
9. 1 2 3 Startles easily
10. 1 2 3 Extremities cold, clammy
11. 1 2 3 Strong light irritates
12. 1 2 3 Urine amount reduced
13. 1 2 3 Heart pounds after retiring
14. 1 2 3 "Nervous" stomach
15. 1 2 3 Appetite reduced
16. 1 2 3 Cold sweats often
17. 1 2 3 Fever easily raised
18. 1 2 3 Neuralgia-like pains
19. 1 2 3 Staring, blinks little
20. 1 2 3 Sour stomach frequent

## GROUP TWO

21. 1 2 3 Joint stiffness after rising
22. 1 2 3 Muscle-leg-toe cramps at night
23. 1 2 3 "Butterfly" stomach, cramps
24. 1 2 3 Eyes or nose watery
25. 1 2 3 Eyes blink often
26. 1 2 3 Eyelids swollen, Puffy
27. 1 2 3 Indigestion soon after meals
28. 1 2 3 Always seems hungry; feels light-headed often
29. 1 2 3 Digestion rapid
30. 1 2 3 Vomiting frequent
31. 1 2 3 Hoarseness frequent
32. 1 2 3 Breathing irregular
33. 1 2 3 Puls slow, feels irregular
34. 1 2 3 Gagging reflex slow
35. 1 2 3 Difficulty swallowing
36. 1 2 3 Constipation, Diarrhea alternating
37. 1 2 3 "Slow starter"
38. 1 2 3 Get "chilled" infrequently
39. 1 2 3 perspire easily
40. 1 2 3 Circulation poor, sensitive to cold
41. 1 2 3 Subject to colds, asthma, bronchitis

## GROUP THREE

42. 1 2 3 Eat when nervous
43. 1 2 3 Excessive appetite
44. 1 2 3 Hungry between meals
45. 1 2 3 Irritable before meals
46. 1 2 3 Get "shaky" if hungry
47. 1 2 3 Fatigue, eating relieves
48. 1 2 3 "lightheaded" if meals delayed
49. 1 2 3 Heart palpitates if meals missed or delayed
50. 1 2 3 Afternoon headaches
51. 1 2 3 Overeating sweets upsets
52. 1 2 3 Awaken after few hours sleep -hard to get back to sleep
53. 1 2 3 Crave candy or coffee in afternoons
54. 1 2 3 Moods of depression- "blues' or melancholy
55. 1 2 3 Abnormal craving for sweets or snacks

## GROUP FOUR

56. 1 2 3 Hands and feet go to sleep easily, numbness
57. 1 2 3 Sigh frequently, "air hunger"
58. 1 2 3 Aware of "breathing heavily"
59. 1 2 3 High alltitude discomfort
60. 1 2 3 Opens windows in closed rooms
61. 1 2 3 Susceptible to colds and fevers
62. 1 2 3 Afternoon "yawner"
63. 1 2 3 Get "drowsy" often
64. 1 2 3 Swollen ankles worse at night
65. 1 2 3 Muscle cramps, worse during exercise get "charley horses"
66. 1 2 3 Shortness of breath or exertion
67. 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion.
68. 1 2 3 Bruise easily, "black and blue" spots
69. 1 2 3 Tendency to anemia
70. 1 2 3 "Nose Bleeds" frequent
71. 1 2 3 Noises in head, or "ringing in ears"
72. 1 2 3 Tension under the breastbone, or feeling of "tightness" worse on excertion

## GROUP FIVE

73. 1 2 3 Dizziness
74. 1 2 3 Dry Skin
75. 1 2 3 Burning Feet
76. 1 2 3 Blurred Vision
77. 1 2 3 Itching skin and feet
78. 1 2 3 Excesssive falling hair
79. 1 2 3 Frequent skin rashes
80. 1 2 3 Bitter, metallic taste in mouth in morning
81. 1 2 3 Bowel movements painful or difficult
82. 1 2 3 Worrier, feels insecure
83. 1 2 3 Feeling quesy; headache over eyes
84. 1 2 3 greasy foods upset
85. 1 2 3 Stools light-colored
86. 1 2 3 Skin peels on foot soles
87. 1 2 3 Pain between shoulder blades
88. 1 2 3 Use laxatives
89. 1 2 3 Stools alternate from soft to watery
90. 1 2 3 History of gallbladder attacks or gallstones
91. 1 2 3 Sneezing attacks
92. 1 2 3 Dreaming, nightmare type bad dreams
93. 1 2 3 Bad breath (halitosis)
94. 1 2 3 Milk products cause distress
95. 1 2 3 Sensitive to hot weather
96. 1 2 3 Burning or itching anus
97. 1 2 3 Crave sweets

## GROUP SIX

98. 1 2 3 Loss of taste for meat
99. 1 2 3 Lower bowel gas several hours after eating.
100. 1 2 3 Burning stomach sensations, eating relieves
101. 1 2 3 Coated tongue
102. 1 2 3 Pass large amounts of foul-smelling gas
103. 1 2 3 Indigetsion 1/2-1 hour after eating; may be up to 3-4 hrs.
104. 1 2 3 Mucous colitis or "irritable bowel"
105. 1 2 3 Gas shortly after eating
106. 1 2 3 Stomach "bloating" after eating

## GROUP SEVEN

(A)

107. 1 2 3 Insomnia
108. 1 2 3 Nervousness
109. 1 2 3 Can't gain weight
110. 1 2 3 Intolerance to heat
111. 1 2 3 Highly emotional
112. 1 2 3 Flush easily
113. 1 2 3 Night sweats
114. 1 2 3 Thin, moist skin
115. 1 2 3 Inward trembling
116. 1 2 3 Heart palpitates
117. 1 2 3 Increased appetite w/o weight gain
118. 1 2 3 Pulse fast at rest
119. 1 2 3 Eyelids and face twitch
120. 1 2 3 Irritable and restless
121. 1 2 3 Cant work under pressure

(B)

122. 1 2 3 Increase in weight
123. 1 2 3 Decrease in appetite
124. 1 2 3 Fatigue easily
125. 1 2 3 Ringing in ears
126. 1 2 3 Sleepy during day
127. 1 2 3 Sensitive to cold
128. 1 2 3 Dry or scaly skin

(D)

129. 1 2 3 Constipation
130. 1 2 3 Mental sluggishness
131. 1 2 3 Hair course, falls out
132. 1 2 3 Headaches upon arising wear off during day
133. 1 2 3 Slow pulse, below 65
134. 1 2 3 Frequency of urination
135. 1 2 3 Impaired hearing
136. 1 2 3 Reduced initiative
137. 1 2 3 Failing Memory
138. 1 2 3 Low blood pressure
139. 1 2 3 Increased sex drive
140. 1 2 3 Headaches, "splitting or rending" type
141. 1 2 3 Decreased sugar tolerance
142. 1 2 3 Abnormal thirst
143. 1 2 3 Bloating of abdomen
144. 1 2 3 Weight gain around hips or waist
145. 1 2 3 Sex drive reduced or lacking
146. 1 2 3 Tendency to ulcers, colitis
147. 1 2 3 Increased sugar tolerance
148. 1 2 3 Women: menstrual disorders
149. 1 2 3 Young girls: lack of menstrual function

(E)

150. 1 2 3 Dizziness
151. 1 2 3 Headaches
152. 1 2 3 Hot flashes
153. 1 2 3 Increased blood pressure
154. 1 2 3 Hair growth on face or body (female)
155. 1 2 3 Suger in urine (not diabetes)
156. 1 2 3 Masculine tendencies (female)

(F)

157. 1 2 3 Weakness, dizziness
158. 1 2 3 Chronic fatigue
159. 1 2 3 Low blood pressure
160. 1 2 3 Nails weak, ridged
161. 1 2 3 Tendency to hives
162. 1 2 3 Arthritic tendencies
163. 1 2 3 Perspiration increase
164. 1 2 3 Bowel disorders
165. 1 2 3 Poor circulation
166. 1 2 3 Swollen ankles
167. 1 2 3 Crave salt
168. 1 2 3 Brown spots or bronzing of skin
169. 1 2 3 Allergies-tendency to asthma
170. 1 2 3 Weakness after colds, influenza
171. 1 2 3 Exhaustion-muscular and nervous
172. 1 2 3 Respiratory disorders.

## GROUP EIGHT

173. 1 2 3 Apprehension
174. 1 2 3 Irritability
175. 1 2 3 Morbid Fears
176. 1 2 3 Never seems to get well
177. 1 2 3 Forgetfulness
178. 1 2 3 Indigestion
179. 1 2 3 Poor appetite
180. 1 2 3 Craving for sweets
181. 1 2 3 Muscular soreness
182. 1 2 3 depression; feelings of dread
183. 1 2 3 Noise sensitivity
184. 1 2 3 Acoustic hallucianations
185. 1 2 3 Tendency to cry w/o reason
186. 1 2 3 Hair is coarse and/or thinning
187. 1 2 3 Weakness
188. 1 2 3 Fatigue
189. 1 2 3 Skin sensitive to touch
190. 1 2 3 Tendency toward hives
191. 1 2 3 Nervousness
192. 1 2 3 Headache
193. 1 2 3 Insomnia
194. 1 2 3 Anxiety
195. 1 2 3 Anorexia
196. 1 2 3 Inability to concentrate; confusion
197. 1 2 3 Frequent stuffy nose; sinus infections
198. 1 2 3 Allergy to some foods
199. 1 2 3 Loose joints

## FEMALE ONLY

200. 1 2 3 Very easily fatigues
201. 1 2 3 Premenstrual tension
202. 1 2 3 Painful menses
203. 1 2 3 Depressed feelings
204. 1 2 3 Menstruation excessive and prolonged
205. 1 2 3 Painful breasts
206. 1 2 3 Menstruate too frequently
207. 1 2 3 Vaginal discharge
208. 1 2 3 hysterectomy/ovaries removed
209. 1 2 3 Menopausal hot flashes
210. 1 2 3 Menses scanty or missed
211. 1 2 3 Acne, worse at menses
212. 1 2 3 Depression of long standing

## MALE ONLY

213. 1 2 3 Prostate trouble
214. 1 2 3 Urination difficult or dribbling
215. 1 2 3 Night urination frequent
216. 1 2 3 Depression
217. 1 2 3 Pain on inside of legs or heels
218. 1 2 3 Feeling of incomplete bowel evacuation
219. 1 2 3 Lack of energy
220. 1 2 3 Migrating aches and pains
221. 1 2 3 Tire too easily
222. 1 2 3 Avoids activity
223. 1 2 3 Leg nervousness at night
224. 1 2 3 Diminished sex drive