Meridian Chiropractic and Acupuncture

2508 25th Street, Suite C

Rock Island, IL 61201

Name____ Home Phone _____________________________________

Street ____City ____________________________ State______ Zip___________

Age_______ Date of Birth_______________ Place of Birth ____

Occupation __________________________________ Work Phone ____________________ Retired_________________________

In Emergency Notify ____ email _______________________________

Referred by____________________________________ Family Physician ____

Reason for your visit____

____

____

____

PAST MEDICAL HISTORY

__ Allergies

__ Asthma, COPD

__ Cancer

__ Childhood illnesses__________________

__ Diabetes

__ Heart disease, stroke

__ Hepatitis, liver disease

__ High blood pressure

__ HIV/AID

__ Kidney stones

__ Rheumatic fever

__ Seizures

__ Surgeries & Dates

____

____

____

__ STD______________

__ Thyroid disease

__ Gallbladder disease

__ Vaccinations

__ Other significant illness____________________

__ Significant traumatic injury

____

__ GERD

__ Depression

__ Other___________________________________

____

FAMILY MEDICAL HISTORY

__ Allergies

__ Asthma, COPD

__ Cancer

__ Diabetes

__ Heart disease, stroke

__ High blood pressure

__ Seizures

__ Liver disease

__ Other __________________________

CURRENT GENERAL HEALTH INDICATORS - please check all that apply

__ Poor appetite

__ Disturbed sleep

__ Fatigue

__ Poor coordination

__ Weight gain/loss

__ Cold hands/ feet

__ Night sweats

__ Cold abdomen

__ Changes in appetite

__ Heavy sleep

__ Strong thirst

__ Fevers

__ Poor balance

__ Poor memory

__ Lack of concentration

__ Easy bleeding/bruising

__ Cold back

__ Chills

__ Headaches

__ Sensitive to smells or tastes

__ Cravings

__ Sudden drop in energy (time:___________)

__ Changes in bowels

__ Changes in urination

__ Any other unusual or abnormal condition _______

____

____

____ Pain

LIFESTYLE AND HABITS

Exercise____ Other, i.e. yoga, tai chi ____________________________________

__ Meditation __Biofeedback

Occupational stress factors ____

Habitual consumptions: ___ Cigarettes __ Alcohol __Coffee, tea, soda __Other ___________________________

Dietary considerations:____

Medications and/or supplements____

____

____

____

SKIN AND HAIR

__ Rashes
__ Itching
__ Dandruff
__ Easy bruising
__ Ulcerations
__ Eczema
__ Psoriasis
__ Hair loss
__ Hives
__ Pimples
__ Recent moles
__ Recent changes in hair or skin texture
__ Other ________________
____

HEAD, EYES, EAR, NOSE, THROAT

__ Dizziness
__ Glasses
__ Eye pain
__ Black spots, floaters
__ Color blindness
__ Copious saliva
__ Dry eyes, itchy eyes
__ Dry throat
__ Sinus problems
__ Grinding teeth
__ Teeth, gum problems
__ Concussions
__ Poor vision
__ Facial pain
__ Cataracts
__ Earaches
__ Dry mouth
__ Recurrent sore throat
__ Sores on lips, tongue
__ Migraines
__ Headaches : where_____________
frequency _____________
__ Ringing in the ears
__ Nose bleeds

CARDIOVASCULAR

__ Dizziness
__ Irregular heartbeat
__ Cold hands or feet
__ Blood clots
__ Pain in legs with walking
__ Low blood pressure
__ High blood pressure
__ Swelling of hands
__ Swelling of feet
__ Difficulty breathing
__ Chest pain or pressure
__ Fainting
__ Phlebitis
__ Spontaneous sweating
__ Chest tightness
__ Any other cardiac problems ____

RESPIRATORY

__ Cough
__ Bronchitis
__ Asthma
__ Difficulty breathing lying down
__ Coughing up blood
__ Coughing up mucus
__ Color of mucus
__ Thick mucus
__ Thin mucus
__ Pneumonia
__ Frequent colds
__ Pain with inhalation
__ Difficulty inhaling
__ Difficulty exhaling
__ Easily sweat
__ Any other lung problems ____

GASTROINTESTINAL

__ Nausea
__ Vomiting
__ Abdominal cramps or pain
__ Constipation
__ Diarrhea
__ Black stools
__ Gas
__ Bloating
__ Blood in stools
__ Mucus in stools
__ Rectal pain
__ Hemorrhoids
__ Belching
__ Indigestion, heartburn
__ Food sensitivities
__ Stomach always grumbling
__ Easily full when eating
__ Always feel hungry
__ Laxatives
__ Any other GI problems ____

GENITOURINARY

__ Pain with urination
__ Urgency
__ Incontinence
__ Dribbling
__ Decrease in flow
__ Frequent urination
__ Waking at night to urinate
__ Color of urine ______________
__ Cloudiness
__ Blood in urine
__ Kidney stones
__ Sores on the genitals
__ Itching genitals
__ Sweating in genitals
__ Strong odor to urine
__ Impotence
__ Decreased libido
__ Increased libido
__ Early ejaculation
__ Any other genitourinary problems ____

REPRODUCTIVE AND GYNECOLOGICAL

Age at menarche ____
Length of menses ________
Length of cycle __________
__ Painful menses
__ Heaviness in pelvis
__ Back pain with menses
__ Clots
__ Color of flow ________
__ Strong odor
__ Vaginal discharge ________

__ Vaginal odor
__ Irregular menses
__ No menses
__ Bleeding between menses
__ PMS
__ Breast lumps, swelling, discharge
__ Pregnancies: how many ______
__ Miscarriages, abortions ______
__ Premature births _____
__ Diarrhea with menses

__ Headache with menses
__ Nosebleed with menses
__ Birth control
__ Infertility
__ Infertility treatments: __________________
____
____
___ Surgeries __________________________
____
____

MUSKULOSKELETAL

__ Neck pain
__ Back pain
__ Sacral pain
__ Osteoarthritis

__ Shoulder pain
__ Knee pain
__ Ankle, foot pain
__ Rheumatoid arthritis

__ Wrist, hand pain
__ Hip pain
__ Leg pain
__ Fibromyalgia

__ Muscle weakness
__ Muscle pain
__ Numbness, location____________________
__ Scleroderma

Joint injuries or surgeries ____
____

Any other musculoskeletal problems ____
____

NEUROLOGICAL / PSYCHOLOGICAL

__ Seizures
__ Stroke
__ Areas of numbness ____________
__ Areas of weakness ____________
__ Paralysis
__ Concussion
__ Dizziness

__ Poor memory
__ Poor concentration
__ Lack of coordination
__ Depression
__ Bad temper, irritability
__ Worry about everything
__ Considered suicide

__ Loss of balance
__ Anxiety, panic attacks
__ Insomnia
__ Rages
__ Easily susceptible to stress
__ Fearful for no reason
__ Neuropathy ____________

Any other neurological problems ____
____

ANY OTHER CONCERNS

____
____
____
____

PRACTITIONER SECTION BELOW HERE

Classical Considerations and Diagnostic Inquiry - Looking, Listening, Smelling, Palpating:

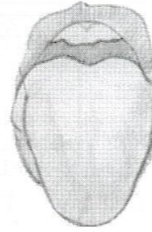
Color ________________________
Type ________________________
Tone ________________________
Odor ________________________

Yin/Yang Balance _________________________________
Firm/Weak _________________________________
Hot/Cold _________________________________
Surface/Interior _________________________________

Preference	Most liked	Least liked
Season	_________	_________
Taste	_________	_________
Time of day	_________	_________
Climate	_________	_________

TONGUE DIAGNOSIS

__ Pink	__Yellow coat	__ Hard	
__ Pale	__ White coat	__ Lolling	
__ Red	__ No coat	__ Swollen	
__ Dusky	__ Peeled/mirror	__ Scalloped	
__ Blue/purple	__ Geographic	__ Cracks	
__ Purple spots	__ Greasy	__ Ulcers/sores	
__ Dry	__ Rough	__ Curled	
__ Wet	__ Prickles	__ Quivery	
__ Moist	__ Spots		



Sublingual Surface

__ Pale
__ Pink
__ Red
__ Dark veins
____
____
____
____

PULSE DIAGNOSIS AND ABDOMINAL PALPATION

Left Pulse

Chi	Guan	Cun
+	+	+
+	+	+
+	+	+

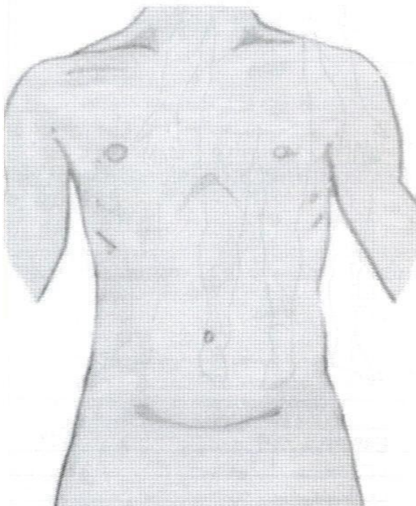
Quality ___________________________
Shape ___________________________
Force ___________________________

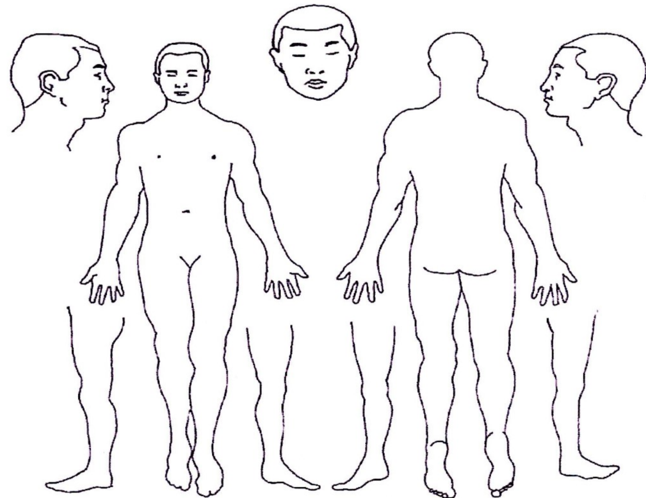
Right Pulse

Cun	Guan	Chi
+	+	+
+	+	+
+	+	+

Quality___________________________
Shape ___________________________
Force ___________________________

Other observations: ____





ASSESSMENT

Objective Symptoms________________________
____
____

General Diagnosis______________________________________
____
____

Subjective Symptoms_______________________
____
____

Treatment Strategy_____________________________________
____
____

Points: ____
Moxa: ____
Herbal Formula & Dosage: ____
____
____
Dietary Recommendations: ____
____
Exercise Recommendations: ____
Follow-up: ____