pure meridian
wellness at its best

Patient Name: _____ **Date:** ____/____/____

Address: _____

Home Phone _____ Cell Phone: _____

Email _____ Age: _____

Please check one answer for each question.

Meridian	Question	Never	Sometimes	Often
LY	Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.?			
LU	Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.?			
LI	Do you experience bouts of diarrhea or constipation, gas, bloating?			
NE	Do you experience irritability, nervousness, trembling, anxiety, or memory problems?			
CI	Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.?			
AL	Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.?			
OR	Do you have slow metabolism, are you always hungry, have low energy at specific times of day?			
TW	Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.?			
HT	Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.?			
SI	Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating, etc.?			
GV	Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.?			
PA	Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.?			
SP	Do you experience chronic fatigue, recurring infections, lowered immune response, etc.?			
LV	Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.?			
JO	Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.?			
FI	Do you have fibromyalgia, rheumatism, carpel tunnel, slow recovery after exercise, etc.?			

Meridian	Question	Never	Sometimes	Often
SK	Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis, etc.?			
FA	Do you have lipomas, degenerative liver disease, breast tumors, problems burning fat, etc.?			
KI	Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.?			
UB	Do you have recurring infections, itching or yeast problems, painful urination, "leaking", etc.?			
Female	Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, hot flashes, menopausal symptoms, etc.?			
Male	Do you experience urinary discomfort, frequency of urination, etc.?			
Teeth	Do you have sensitive teeth or experience pain or discomfort in the teeth, gums, or jaw region?			
Stress	Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments?			
Energy	Do you lack motivation, drive, perseverance, stamina, or endurance?			
Well-Being	Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?			
Immune	Are you susceptible to infections, allergies, or sensitive to pollution, or work environment?			

LY= Lymphatic
LU= Lung
LI=Large Intestine
NE= Nervous System
CL= Circulatory
AL=Allergies
OR=Cellular Metabolism
TW=Endocrine Glands
HT=Heart
SI=Small Intestine
PA=Pancreas
LV=Liver
JO=Joints
ST=Stomach
FI =Fibroid Tissue
SK=Skin
FA=Fatty Tissue
GB=Gall Bladder
KI=Kidney
UB= Uterus/Prostate
SP=Spleen

Primary Complaint _____

Health Goals_____

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Are you under a Doctors care? (Yes or No)

If yes please explain _____

Are you taking any medication? (Yes or No)

If yes please list : _____

Are you aware of any allergies that you may have? (Yes or No)

If yes, please list : _____

What physical activities do you enjoy? _____

How often are you physically active? _____

How many hours of sleep do you average on a daily basis? _____

Do you sleep through the night? (Yes or No)

Do you enjoy sweets? (Yes or No)

Do you use artificial sweetners? (Yes or No)

What are you favorite foods / drinks? _____

_____

Do you eat breakfast everyday? (Yes or No)

What do you normally eat for breakfast? _____

Do have a family history of cancer? (Yes or No)

Do you have a family history of heart disease? (Yes or No)