



meridian WELLNESS

Patient Information & History

Date: _____

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PATIENT INFORMATION

Name: _____ Birthday (D/M/Y): _____ Age: _____ Male Female
(First) (Initial) (Last)

Address: _____
(Street) (Apt/Ste #) (City) (Postal Code)

Home phone: _____ Work/Cell Phone: _____ Email: _____

Single Married Occupation: _____

Parent's Name (if a minor): _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone: _____ Cell: _____

Office use only: Credit card # _____ Exp. _____

How did you hear about us?

- Sign
- Yellow pages
- Internet
- Radio
- Magazine
- Friend _____
- Seminar
- Dr. _____
- Other _____

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CURRENT HEALTH CONCERNS

What are your health concerns in order of importance to you:

- a) _____ c) _____
- b) _____ d) _____

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MEDICAL HISTORY

Current/past illnesses, conditions, and hospitalizations:

List medications or supplements you are currently taking:

_____	_____
_____	_____
_____	_____

Allergies or sensitivities (food, drugs, seasonal, pets, etc.):

Females: Are you currently pregnant? Yes No

Date of last antibiotic use: _____

Date of last physical exam: _____

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DIET & LIFESTYLE

Please list a typical day's diet:

Breakfast _____
 Snack _____
 Lunch _____
 Snack _____
 Dinner _____
 Snack _____

Water _____ glasses per day

Alcohol _____ drinks per week

Sleep _____ hours per day

Smoking _____ cigarettes per day

Exercise _____ times per week

Stress Levels: Low Moderate High

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FAMILY HISTORY

Please indicate if a close relative (parent, child, sibling, grandparent) has had any of the following:

Allergies	Depression
Asthma	Other mental illness
Heart disease	Drug abuse
High blood pressure	Alcoholism
Cancer	Kidney disease
Diabetes	Other

Family MD: _____ Address: _____ Phone: _____

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REVIEW OF SYSTEMS

Please check the condition if you have it now or have had it in the past.

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excess thirst | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Exposure to toxins/chemicals | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye floaters | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye redness/itching/discharge | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Pain on urination |
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibrocystic breast | <input type="checkbox"/> Painful menses |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Headaches | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Bloating/gas | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Blood/mucous in stool | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Heavy menses | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hernias | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Infertility | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Irregular menstrual cycle | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Deafness/impaired hearing | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dental cavities | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leg pain/cramps | <input type="checkbox"/> Testicular mass/pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lines on nails | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Urinary urgency |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Urination at night |
| <input type="checkbox"/> Earache/infections | <input type="checkbox"/> Migraines | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Vaginal itching |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Nail fungus | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Weight gain (unexplained) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Weight loss (unexplained) |
| <input type="checkbox"/> Excess hunger | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Excess sweating | <input type="checkbox"/> Numbness/tingling | |

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INFORMED CONSENT FOR NATUROPATHIC TREATMENT

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment.

Dr. Jennifer Grochocinski, ND uses the following modalities in her practice: diet and nutritional counselling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, and lifestyle counselling.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes, heart/liver/kidney disease. It is very important therefore that you inform Dr. Grochocinski immediately if any of the above applies to you. Because each individual may respond differently to treatment, Dr. Grochocinski may not be able to anticipate and explain ALL risks and complications and cannot guarantee results.

There are some risks to treatment by Naturopathic Medicine. These include but are not limited to aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain/bruising/injury from acupuncture and massage, fainting or puncturing of an organ with acupuncture needles.

I understand that my case may be discussed for educational purposes and information from my medical record may be analyzed for research purposes in which my identity will be kept confidential.

I acknowledge that I have discussed, or have had the opportunity to discuss, with Dr. Grochocinski the nature and purpose of naturopathic treatment in general and my treatment in particular as well as the contents of this Consent.

I consent to the naturopathic treatments offered or recommended to me by Dr. Jennifer Grochocinski, ND. I intend this consent to apply to all my present and future naturopathic care.

Patient Name

Signature of Patient/Guardian

Date

Witness Name

Witness Signature

Stay Informed & Protect our Environment!

In our effort to save paper and trees, we will be transitioning to sending monthly updates to our patients electronically. You will find these updates valuable as they contain information about clinic changes and recent news, as well as up-to-date advisories/recalls on herbs and supplements. Occasionally, we may need to contact you by email if we cannot reach you by phone. Your email will remain confidential with us and you may unsubscribe at any time. Please check the appropriate box and print your email on the first page if applicable.

Yes, I would like updates by email

No, I would prefer to receive paper updates.

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PHYSICAL EXAMINATION - Doctor use only

General - mood, gait

Vitals - BP _____ PR _____ RR _____ T _____ Weight _____ Height _____

Skin - colour, temperature, texture, moisture, turgor, lesions

Head - symmetry, lumps, lesions, tenderness, hair (loss, texture), sinuses, clench, TMJ, light touch, facial expression, shrug

Neck - nodes, thyroid, swallow, tracheal deviation

Eyes - lids, brows, lashes, colour, edema, discharge, sclera, cornea, conjunctiva, visual fields, eye movements, nystagmus, convergence, accommodation, pupillary reflex, cover/uncover, acuity, fundoscopy

Nose - lumps, tenderness, patency, acuity, mucosa (colour, vessels, septum, polyps)

Mouth - lips, gums, teeth, mucosa, glands, tonsils, pharynx, tongue, gag reflex

Ears - lesions, discharge, palpate (pinna, tragus, mastoid), finger rub, acuity (Weber, Rinne), otoscopy

Thorax - spine curvature, fremitus, expansion, percussion, excursion, kidney punch, auscultation, axillary nodes

Chest - carotids, thyroid, apical impulse, auscultate

Abdomen - lesions, auscultate (quadrants, arteries), percuss (quadrants, liver span, spleen), palpate (abdomen, liver, kidneys, inguinal nodes, aortic pulse), abdominal reflex

Extremities - symmetry, leg edema, temperature, nails, capillary refill, palpate pulses

NeuroMSK - ROM, hand strength, DTR, toe proprioception, stereognosis, graphesthesia, pain (sharp/dull), vibration, coordination (rapid movement, finger/nose), heel-to-toe, Romberg