Meridian Therapeutics Clinic

Registration Form

Date: _____

Name:	DOB:
Marital Status: please circle Single Partnered Married Separated Divorced Widowed	
Reason For Visit:	Primary Provider Name and Phone Number:
Allergies to medications:	Food/ Seasonal, Environmental Allergies:

Are you Pregnant?	Yes	No	NA	Date of Last Menstrual Cycle:

Health History: Do you currently have or have had any of the following. If you have a Hx of condition place H in box.

	Yes	No		Yes	No		Yes	No
Current Fever or chills			Allergies			Genital or Oral Herpes		
Unexplained Weight Loss			Asthma			Urinary Tract Infection		
HIV / Oth Blood Disease			Sleep Apnea			Problems Urinating		
Thyroid Problems			Sinus Issues			STIs/ STDs		
Diabetes			Skin Issues/ Problems			Fatigue		
Hormonal Imbalance			Headaches/ Migraines			Low energy		
Arthritis			Stroke/ TIAs			Chronic Pain		
Mobility/ Joint Problems			Seizures/ Epilepsy			Anxiety		
Constipation/ IBS			Kidney Problems			Depression		
Diarrhea/ IBS			Vision Problems			Mood Swings		
Nausea/ Vomiting			Hearing Problems			ADHD		
GI /Liver Problems			Nerve Damage/ Neuropathy			Hx of Blood Clots		
Heart Disease			Swelling/ Edema			Cancer		
High Blood Pressure			Implanted Devices					

Health Habits and Occupational Concerns

Habit	Yes	No	Frequency		Yes	No	Frequency
Exercise				Stress			
Caffeine				Hazardous			
Diet – special diets				Heavy Lifting			
Drugs				Other:			
Alcohol							
Tobacco							

Current Medications and Supplements – provide dosing and frequency

Patient (guardian) Signature: _____

By filling out this history form you thereby consent to treatment. You have the right to refuse recommendations, supplements, medications (whether herbal or pharmaceutical) offered from the provider.

Informed Consent for and Authorization for Treatment

I understand that the evaluation diagnosis and treatment by a Holistic Medical Provider, Nurse Practitioner, Naturopathic Physician, and or Licensed Acupuncturist, may include but is not limited to:

- Consultation (Acute visit, Psychiatric, and Medical) with Physical Examination
- Common diagnostic procedures (such as, diagnostic imaging, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (such as the therapeutic use of foods, diet plans, nutritional supplements, and intramuscular injections)
- Traditional Chinese Medicine: Acupuncture (insertion of specialized disposable stainless-steel sterilized needles through the skin into underlying tissues at specific points on the body surface)
- Botanical (Herbal) medicines and nutraceuticals [also referred to as supplements] (such as the prescribing of various therapeutic substances including plant, mineral and animal materials. Substances may be given in the forms of teas, pills, creams, powders, tinctures - which may contain alcohol.
- Electrical stimulation and use of TENS units with or without acupuncture
- Homeopathic medicines (highly diluted substances) and Flower Essences
- Over the counter medication recommendations
- Prescription medications, as needed, to be filled at a pharmacy as necessary.

I understand and I am informed that in the practice of Holistic Medicine there are risks with evaluation, diagnosis and treatment including but not limited to the following:

Potential risks: pain/ discomfort, minor bruising, soreness from electrical stim/ TENS, acupuncture/ cupping, allergic reaction to herbs, supplements, prescriptive medications, and aggravation of previous or recent symptoms.

Potential Benefits: restoration of body's functional capacity, relief of pain, reduced symptoms of illness, assistance in injury and disease recovery process and disease prevention.

Notice to pregnant women: all female patients must alert the provider that they are pregnant, since some therapies can be harmful.

The medical provider has the right to treat me within their scope of practice. The provider also has the right to refuse treatment or make referrals that they feel are needed in my care.

By signing below, I (print name), _____acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I also understand that it is my responsibility to request that the provider explain therapies and procedures to my satisfaction. I further acknowledge that no guarantees have been given to me concerning the results intended from the treatment. I intend that this consent form is to cover the entire course of treatments for my present condition and any future conditions for which I am seeking treatment. I understand that I may withdraw my consent and discontinue participation in these treatments at any time.

Patient Name: (Please Print) _____

Signature of Patient or Guardian _____

Date: _____ Provider Signature: _____