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# BIOMERIDIAN QUESTIONNAIRE

Patient's Name: _____ Date: __ __ / __ __ / __ __

***Please answer the following questions with one of these five responses.***
***Please mark one answer for each question***

**1= NEVER 2= RARELY 3= SOMETIMES 4= FREQUENTLY 5= DAILY**

Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes. _____

Do you experience recurrent respiratory infections, coughs, bronchitis? _____

Do you experience bouts of diarrhea or constipation, gas, bloating? _____

Do you experience irritability, nervousness, anxiety, memory problems? _____

Do you have cold fingers or toes, blood pressure problems, varicose veins, atherosclerosis? _____

Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander? _____

Do you have slow metabolism, are you hungry, have low energy at specific times of day? _____

Do you have mood swings, problems sleeping, are you always cold? _____

Do you experience palpitations, arrhythmia, weak heart valves? _____

Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating? _____

Do you experience spinal pain or stiffness, headaches, depression? _____

Do you have diabetes, hypoglycemia, shaking if you miss a meal? _____

Do you experience chronic fatigue, recurring infections, lowered immune response? _____

Do you experience pain in the liver area, hepatitis, high cholesterol? _____

Do you have arthritis, back pain, pain with movement or weather change? _____

Do you experience indigestion, heartburn, bloating or gas after meals? _____

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Do you have fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise? _____

Do you have rashes, dryness, scaly patches, eczema, acne, psoriasis? _____

Do you have lipomas, fibrocystic breasts, fatty liver? _____

Do you have gallstones, discomfort after eating rich foods? _____

Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders? _____

Do you experience gout, edema, kidney stones, burning urination? _____

Do you have recurring bladder infections, leaking, itching or yeast problems? _____

Do you have PMS, menstrual pain, irregular periods, fibroids? _____

Do you experience frequency of urination, getting up at night to urinate? _____

Do you have sensitive teeth, gum disease or pain in the jaw? _____

Are you susceptible to infections, allergies or sensitive to pollution or work environment? _____

Do you experience stress from work, finances, society or relationships that you feel cause physical ailments? _____

Patient or Guardian: _____ Date: __ __ / __ __ / __ __

Witness: _____ Date: __ __ / __ __ / __ __