IMPROVED performance, inc.
Acupuncture & Massage Therapy • 895 rue St. Francois, Florissant • 314 921-3366
Mary S. Wallis, L.Ac, L.M.T.
National Board Certified in Acupuncture (NCCAOM) • MO License No. 2007002923

Patient Intake Form

Today's Date _____

Name _____ SSN N / A

Date of Birth _____ Age _____ Male ☐ Female ☐ Marital Status _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

Email address _____

Employer _____ Occupation _____

Emergency contact _____ Relationship _____

Contact information _____

How did you learn of Mary S. Wallis, L.Ac.? _____

Responsible party (if dependent) _____

_____

Relationship _____

_____

Contact information _____

_____

_____

_____

Insurance Company Name N / A Telephone _____

Insurance Plan Name _____

Insurance Company Address

Address _____ City _____ State _____ Zip _____

Patient's Policy Number _____ Group Number _____

Purpose of Visit: _____

_____

_____

Location of pain/discomfort: _____

_____

_____

Date current problem began_____ Have you had this problem in the past? Yes ☐ No ☐

If so, when? _____

Is your condition: ☐ getting worse ☐ constant ☐ comes and goes

Is the pain: ☐ slight ☐ moderate ☐ severe

What makes it better? _____

What makes it worse? _____

How does it interfere with your daily activities (work, sleep, sex, etc.)? _____

_____

_____

Have you been given a diagnosis for this problem? If so, what is that diagnosis? _____

_____

What kinds of treatment have you tried? _____

_____

_____

Any other complaints/ pre-existing conditions? _____

_____

_____

What medications/ drugs/ herbs/ supplements are you presently taking? _____

_____

_____

Are you presently under the care of a physical and/ or mental health care provider? If so, by whom and for what condition(s)?

_____

_____

_____

Date of your last physical exam: _____ by whom? _____

Do you have, or have you had, any of the following?

☐ Arthritis	☐ Asthma	☐ Anemia	☐ Heart Disease
☐ Cancer	☐ Stroke	☐ Hepatitis	☐ Chronic Fatigue
☐ Diabetes	☐ Gallstones	☐ Thyroid Disease	☐ Immune Deficiency
☐ Seizures	☐ Ulcers	☐ Venereal Disease	☐ High Blood Pressure

☐ Other _____

Is there any history in your family of any of the above conditions? Who? What did they have? _____

_____

_____

List all surgeries/ operations you have had and the dates performed. (Including oral surgeries, i.e. wisdom teeth) _____

_____

List any traumas you had and dates (accidents, injuries, etc.) _____

_____

_____

_____

List any allergies (food, medications, pollens): _____

_____

_____

Is your energy level: ☐ Good ☐ Insufficient ☐ Erratic

☐ Low (time of day) _____ ☐ High (time of day) _____

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Dream disturbed

☐ Restful ☐ Other _____

Stress: ☐ None ☐ Moderate ☐ Severe

What causes it?_____

_____

_____

How much alcohol do you consume a week? _____

Do you smoke? How much per day? How many years? _____

How much coffee/ tea/ cola/ caffeinated beverages do you consume per week? _____

Do you have a regular exercise program? Please describe. _____

_____

_____

_____

General: Please check all that apply.

☐ Sweating easily ☐ Night sweats ☐ Cold ☐ Hot

☐ Cravings ☐ Bleeding or bruising ☐ Tremors ☐ Fever

☐ Poor coordination ☐ Strong thirst ☐ Lack of thirst ☐ Breast fed as child

☐ Breast feeding ☐ Other _____

Digestion: Please check all that apply

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Stomach Aches

☐ Changing Appetite ☐ Abdominal Pain ☐ Bad breath ☐ Diarrhea

☐ Poor Appetite ☐ Heartburn ☐ Abdominal Bloating ☐ Bloody stools

☐ Excessive Appetite ☐ Belching ☐ Gas ☐ Hemorrhoids

☐ Feel tired or weak if meal is missed ☐ Excessive thirst ☐ Tired after eating

☐ Other _____

Do you:

- [ ] Eat frequently between meals
- [ ] Eat when you're not hungry
- [ ] Eat until you feel full
- [ ] Occasionally go on crash diets
- [ ] Binge
- [ ] Follow a restricted diet
- [ ] Eat sweets every day

Please describe your "average" daily diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks/ time of day eaten _____

Musculoskeletal: Please check all that apply

Pain, weakness, and or numbness in:

- [ ] Neck
- [ ] Shoulders
- [ ] Arms/Hands
- [ ] Feet/Legs
- [ ] Hips
- [ ] Knees
- [ ] Upper Back
- [ ] Mid Back
- [ ] Low Back

Are you experiencing cramps/ spasms, stiffness, swelling? If so, where? _____

_____

Do you have a feeling of heaviness in your body? Where? _____

_____

Cardiovascular/ Respiratory: Please check all that apply.

- [ ] Palpitations
- [ ] Chest pain/pressure
- [ ] Coughing blood
- [ ] Fainting
- [ ] Difficulty breathing
- [ ] Cold Hands/feet
- [ ] Wheezing
- [ ] Coughing phlegm
- [ ] Persistent coughing
- [ ] Irregular heartbeat
- [ ] Dizziness/lightheaded
- [ ] Other

Head: Please check all that apply

- [ ] Headaches (what area and how often?)

- [ ] Dizziness
- [ ] Neck pain
- [ ] Grinding teeth
- [ ] Jaw clicks
- [ ] Tooth problems
- [ ] Migraines
- [ ] Facial pain
- [ ] Other _____

Eyes: Please check all that apply.

- [ ] Glasses/ contacts
- [ ] Dryness
- [ ] ain/burning
- [ ] Itching
- [ ] Redness
- [ ] Blurred vision
- [ ] Floaters
- [ ] Other _____

Ears: Please check all that apply.

- [ ] Poor hearing
- [ ] Earaches
- [ ] Ear infections
- [ ] Poor balance
- [ ] Ringing or buzzing in ears
- [ ] Other _____

Nose: Please check all that apply.

- [ ] Excessive mucus
- [ ] Blocked sinuses
- [ ] Sinus pressure/pain
- [ ] Allergies/hay fever ___
- [ ] Nose bleeds
- [ ] Other _____

Throat/ Mouth: Please check all that apply.

☐ Reoccurring sore throat ☐ Hoarseness ☐ Difficulty swallowing
☐ Bleeding gums ☐ Sores on lips/tongue ☐ Other _____

Urine: Please check all that apply.

☐ Up at night to urinate ☐ Unable to hold urine ☐ Hard to urinate ☐ Pain/burning _____
☐ Blood in urine ☐ Urinary infections ☐ Water retention ☐ Kidney stones
☐ Other _____

Female:

Are you pregnant? _____ Date of last period _____

Number of days between periods _____ Age started _____ Age stopped _____

Form of birth control _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____

Operations:

☐ Cervix ☐ Uterus ☐ Ovaries

Other: Please check all that apply.

☐ Menstrual pain/cramps ☐ Low back pain ☐ Leg cramps ☐ Painful breasts
☐ Clotting ☐ Heavy bleeding ☐ Light bleeding ☐ Dark color
☐ Water retention ☐ Irregular periods ☐ Missed periods ☐ Little/no sex drive
☐ Mood swings ☐ Hot flashes ☐ Food cravings ☐ Vaginal soreness
☐ Genital sores ☐ Infections ☐ Discharge (color) ☐ Other _____

Male: Please check all that apply.

☐ Low sex drive ☐ Impotence ☐ Painful ejaculation ☐ Discharges
☐ Sores ☐ Painful urination ☐ Premature ejaculation ☐ Prostate problems
☐ Nocturnal emissions ☐ Erectile disfunction ☐ Other _____

Neuropsychological: Please check all that apply.

☐ Nervousness ☐ Depression ☐ Easily angered/irritated ☐ Frequent crying
☐ Worry/anxiety ☐ Mood swings ☐ Memory confusion ☐ Poor concentration
☐ Suicidal ☐ Dizzy ☐ Seizures ☐ Neuralgia
☐ Numbness/tingling (where?) _____
☐ Other _____

Is there anything else that you would like for us to know? _____

_____

_____

_____

_____

Acupuncture is the insertion of a thin solid sterile needle into the surface of the body. A patient may feel a slight pricking sensation and or electrical impulse near the needle. Patients usually report little, or no, pain during an acupuncture treatment. On occasion, there may be slight bruising where a needle was inserted. Moxabustion (the burning of the herb, Artemisia Vulgaris or Artemisia Argyi, on the needle to gently warm it enhancing the treatment) may be used. Indirect Moxabustion (the burning of a stick of the above herbs mentioned a finger widths distance from the patients skin) may be used to stimulate the energetics thereby balancing the pulses. Direct Moxabustion (the burning of no larger than rice grain size pellets of herb directly on the acupuncture point) may also be used. The risk of needle and indirect moxabustion is a slight burn resulting in a small blister from falling ash. The risk from indirect and direct moxabustion is a slight burn resulting in a small blister. This rarely happens yet is possible.

The duration of a treatment is usually 30 minutes to an hour. Although, no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient. I, the patient, understand that I have the right to consent to, or refuse, treatment.

Parent or Guardian Consent:

I, _____, as parent or guardian of _____ __, authorize treatment of this minor by Mary S. Wallis, L.Ac..

Signature:_____ Date: _____

Patient Consent:

By signing below, I consent to treatment using Meridian Therapy Acupuncture which may include acupuncture, moxabustion, and or oriental handwork therapies.

Signature:_____ Date: _____

Cancellation Policy:

I understand that I may be charged for appointments missed or changed without 24 hours advance notice.

Signature:_____ Date: _____