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 ____________________

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 ____________________ Telephone ____________________

Insurance Plan Name ____________________

Insurance Company Address

Address ____________________ City ____________________ State __________ Zip __________

Patient's Policy Number ____________________ Group Number ____________________

Purpose of Visit: ____________________

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____

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? ______________________

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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: ______________________