



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: \_\_\_\_\_

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?

- |                                      |                                     |   |  |
|--------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Stroke     | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Chronic Fatigue     |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Immune Deficiency   |
| <input type="checkbox"/> Seizures    | <input type="checkbox"/> Ulcers     | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> 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.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Sweating easily   | <input type="checkbox"/> Night sweats         | <input type="checkbox"/> Cold           | <input type="checkbox"/> Hot                 |
| <input type="checkbox"/> Cravings          | <input type="checkbox"/> Bleeding or bruising | <input type="checkbox"/> Tremors        | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Strong thirst        | <input type="checkbox"/> Lack of thirst | <input type="checkbox"/> Breast fed as child |
| <input type="checkbox"/> Breast feeding    | <input type="checkbox"/> Other _____          |   |  |

**Digestion:** Please check all that apply

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Nausea                               | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Changing Appetite                    | <input type="checkbox"/> Abdominal Pain   | <input type="checkbox"/> Bad breath         | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Poor Appetite                        | <input type="checkbox"/> Heartburn        | <input type="checkbox"/> Abdominal Bloating | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Excessive Appetite                   | <input type="checkbox"/> Belching         | <input type="checkbox"/> Gas                | <input type="checkbox"/> Hemorrhoids   |
| <input type="checkbox"/> Feel tired or weak if meal is missed | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Tired after eating |  |
| <input type="checkbox"/> 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
- Pain/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 dysfunction
- 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: \_\_\_\_\_