Virginia Wagenknecht Dipl. OM L.Ac

New patient Intake Form

Name ______________________ , ________________ ____________Date __________________
Last First Middle Month Day Year

Chief concern/reason for visit: ____

When began? ____

Other major concerns:
____

Other symptoms or areas of your body that are bothering you: (please circle)

NEURO: headache—convulsions—seizures—fainting—A.D.D.—stroke__
Other:

EMOTIONAL: depression—anxiety—stress/excess worry—drug/alcohol issues
Other:

EYES: Visual problem—Blurry Vision—Red Eyes
Other:

NOSE: nasal allergies—nose bleeds
Other:

THROAT: swallowing difficulty—frequent sore throats—speech problems
Other:

MOUTH: dental problems—tongue problems—canker sores
Other:

NECK: swollen glands—thyroid problems
Other:

CHEST: chest pain—asthma—shortness of breath—cough—TB
Other:

HEART: murmurs—palpitations—valve problems—angina
Other:

INTESTINAL: colitis—ulcer gastritis—Barrett's esophagus—polyps—constipation
Other:

URINARY: urinary problems—urinary frequency—burning—kidney stones
Other:

GENITAL: infection—warts—herpes—impotence—sexual difficulty

Other:

UPPER EXTREMITY:

Pain in arm— Carpal Tunnel—shoulder pain—elbow pain—wrist pain

Other:

LOWER EXTREMITY

Leg pain—knee pain—hip pain—ankle pain—tingling--- Numbness

Other:

SPINE: low back pain—neck pain—mid back pain—scoliosis—herniated disc—sciatica

Other:

SYSTEMIC: weight loss—fever—night sweats—trouble sleeping—loss of energy—arthritis

Other:

I smoke: ______________ per day I drink _________________ (alcohol) per week

ALLERGIES TO MEDICATIONS: (State drugs and their reactions)

____

SURGERIES: (list type of surgery, year performed or your age at the time of surgery)

____

MEDICATIONS OR SUPPLEMENTS YOU TAKE REGULARLY

____

WHAT SIGNIFICANT ILLNESSES HAVE YOUR NEAREST RELATIVES SUFFERED FROM?

PARENTS?____

SIBLINGS?____

GRANDPARENTS / UNCLE / AUNT ?____

Please list any other information you believe we need to be aware of: (use the back of this page if you need more room):

Date______________________Signature____