BODYWISE WELLENSS & SPA ~ PATIENT INTAKE FORM

Name _____ Date _____

Date of Birth _____ Phone _____Gender: ☐ Male ☐ Female

Email_____

NOW: ☐ Pregnant ☐ Pacemaker ☐ HIV Disease ☐ Hepatitis ☐ Blood Transfusion

FAMILY HISTORY:

☐ Abuse
☐ AIDS
☐ Alcoholism
☐ Allergies
☐ Asthma
☐ Cancer
☐ Chemical Dependency
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Mental Illness
☐ Respiratory Diseases
☐ Seizures
☐ Stroke
☐ Other
_____
_____
_____

YOUR PAST MEDICAL HISTORY/ILLNESSES:

☐ Aids/HIV
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Auto Immune Disease
☐ Bleeding Disease
☐ Breast Cysts
☐ Bi Polar
☐ Bronchitis
☐ Cancer
☐ Candida (Yeast)
☐ Chemical Dependency
☐ Chronic Fatigue Syndrome
☐ Chronic Lung Disease
☐ Colitis
☐ Diabetes
☐ Eating Disorder
☐ Fracture
☐ Glaucoma
☐ Gall Stones
☐ Gout
☐ Headaches
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Low Blood Pressure
☐ Migraine
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mental Illness
☐ Osteoporosis
☐ Organ Transplant
☐ Parkinson's
☐ Pneumonia
☐ Prostate problems
☐ Rheumatic Fever
☐ Seizures/Epilepsy
☐ Sexually Transmitted Diseases (STD)
☐ Stroke
☐ Substance Abuse/Addiction
☐ Suicide Attempt
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Vaccine Reaction
☐ Whooping Cough
☐ Other
_____
_____
_____

SURGERIES (PLEASE INCLUDE DATES AND IF ANY COMPLICATIONS.):

1 -_____ 2_____
3- _____ 4_____

TRAUMATIC INJURY (PLEASE INCLUDE DATES AND IF ANY COMPLICATIONS.):

Car accident(s) _____
Fall(s) _____
Other _____

ALLERGIES:

Drugs/Medication _____
Chemicals _____
Food _____ Seasonal/Environmental _____

CURRENT MEDICATIONS:

1 -_____ 2_____
3- _____ 4_____
5 -_____ 6_____

OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:

Chemical: _____Acid/Alkalines: _____
Electrical: _____Physical Labor: _____
Heavy Metals: _____ Psychological: _____

HABITS/EXCESSIVE USAGE: (PLEASE TELL US HOW OFTEN & HOW MUCH.):

☐ alcohol_____ ☐ artificial sweetener _____ ☐ chocolate_____ ☐ cigarettes _____
☐ coffee _____ ☐ cola_____ ☐ drugs _____ ☐ exercise_____ ☐ food_____
☐ salt _____ ☐ sex _____ ☐ sugar _____ ☐ tea _____ ☐ water _____ ☐ other _____

CHIEF COMPLAINT/REASON FOR YOUR VISIT: _____

How and when did this condition begin? _____
_____

Please list your main health concerns you would like to be free of, in order of importance:

1. _____ 2._____
3._____4. _____

GENERAL:

GENERAL (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS)

☐ poor appetite
☐ change in appetite ☐ large appetite
☐ cravings
☐ weight gain
☐ weight loss
☐ sleep walking
☐ weakness
☐ fevers
☐ sweating
☐ insomnia
☐ hours of sleep_____
☐ easy to fall asleep
☐ heavy sleeper
☐ light sleeper
☐ disturbing dreams
☐ trouble staying asleep
☐ sleep apnea
☐ dizziness
☐ Vitamins
☐ bleeds easily
☐ bruises easily
☐ chronic fatigue
☐ lethargy
☐ fatigue/tired
☐ sudden drop in energy
☐ vertigo
☐ bitter taste
☐ headache
☐ mental fog
☐ diff loosing/gaining weight
☐ excessive need for sleep
☐ chills
☐ trouble falling asleep
☐ hot flashes
☐ tremors/shaking
☐ edema
☐ poor coordination
☐ Herbs
☐ Supplements

Energy Level: ☐ high ☐ moderate ☐ low
Thirst Desires: ☐ hot ☐ cold ☐ room temp. ☐ no desire
Cold Sensations: ☐ hands ☐ feet ☐ back
Are you taking: ☐ Aspirin ☐ Blood Thinners
Heat Sensations: ☐ hands ☐ feet ☐ solar plexus ☐ abdomen ☐ whole body
Stiffness: ☐ joints ☐ back ☐ limbs
Intolerance to: ☐ hot ☐ cold ☐ wind ☐ fan ☐ A/C
Do you make time for relaxation, meditation, or prayer? ☐ yes ☐ no
Do you follow a special diet: ☐ yes ☐ no
If so, please explain: _____

SKIN AND HAIR (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ rashes
☐ eczema
☐ sores
☐ ulcers
☐ herpes
☐ psoriasis
☐ eruptions
☐ discharge
☐ pimples/acne
☐ bruises
☐ itching
☐ hives
☐ change in skin texture
☐ dandruff
☐ loss of body hair
☐ change in hair
☐ balding
☐ thinning of hair
☐ fungal/yeast infection
skin type: ☐ dry ☐ moist
☐ other skin problems: _____
☐ other hair problems: _____

HEAD, EYES, EARS, NOSE, MOUTH & THROAT (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

Headaches:
☐ frontal
☐ temporal
☐ occipital

Head:
☐ dizziness
☐ migraine
☐ head injury
☐ facial pain
☐ facial paralysis
☐ sinus issues
☐ head heaviness

Eyes (R/L):
☐ cataract
☐ glaucoma
☐ eye pain
☐ twitching
☐ floaters/spots
☐ poor vision
☐ blurry vision
☐ night blindness
☐ itchiness
☐ glasses
☐ contacts
☐ red eyes

Ears (R/L):
☐ loss of hearing
☐ discharge
☐ earaches
☐ poor hearing
☐ itchiness

Ringing in Ears:
☐ loud
☐ soft
☐ high pitch
☐ low pitch
☐ inflammation
☐ tenderness

Nose:
☐ loss of smell
☐ good sense of smell
☐ nose bleeds
☐ allergies
☐ dry nose
☐ nasal discharge

Amount:
☐ mod
☐ thick

Color:
☐ yellow
☐ white
☐ clear
☐ green

Mouth:
☐ grind teeth
☐ drooling
☐ excess saliva
☐ dry mouth
☐ gum disease
☐ bad breath
☐ gum bleeding
☐ gum swelling
☐ ulcers
☐ sores
☐ taste in mouth

Throat:
☐ dry throat
☐ hoarseness
☐ recurrent
☐ sore throat
☐ loss of voice
☐ difficulty
☐ swallowing
☐ "lump in throat"
☐ frequent
☐ tonsillitis
☐ freq. sore throat

CARDIOVASCULAR (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ high blood pressure
☐ low blood pressure
☐ dizziness
☐ fainting
☐ palpitations
☐ chest pain
☐ cold hands/feet
☐ swelling hands/feet
☐ irregular heart beat
☐ insomnia
☐ difficulty breathing
☐ shortness of breath
☐ dream disturbance
☐ poor memory
☐ mania/delirium
☐ coma
☐ loss of consciousness
☐ heart pounding

RESPIRATORY (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ pneumonia
☐ bronchitis
☐ asthma
☐ coughing blood
☐ wheezing
☐ frequent colds
☐ chronic cough
Cough: How long? _____☐ dry ☐ croup ☐ rapid ☐ other
Phlegm: ☐ thin ☐ thick ☐ clear ☐ white ☐ yellow ☐ green
☐ tightness in chest
☐ sinus infections
☐ sinus congestions
☐ heaviness in chest
☐ post-nasal drip
☐ shortness of breath
☐ fullness in chest
☐ difficulty inhaling
☐ difficulty exhaling
☐ other chest discomfort

GASTROINTESTINAL (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ food allergies
☐ vomiting
☐ cramping
☐ gas after meals
☐ abd/stomach pain
☐ nausea
☐ overeat
☐ tastelessness
☐ fatigue after eating
☐ taste in mouth
☐ belching
☐ bad breath
☐ hiccup
☐ constipation
☐ diarrhea
☐ mouth sores
☐ heart burn/reflux
☐ bulimia
☐ loose stools
☐ bloody/black stools
☐ ulcers
☐ increased appetite
☐ poor appetite
☐ hungry-no desire to eat
☐ dry, hard stools
☐ "nervous stomach"
☐ cravings
☐ difficult stools
☐ mucus in stools
☐ hemorrhoids
☐ hernia
☐ rectal pain
☐ rectal bleeding
☐ gallstones
☐ tenderness in abdomen
☐ fullness in abdomen
☐ burning in abdomen
☐ like/dislike pressure
☐ like/dislike cold
☐ like/dislike warmth
☐ difficulty swallowing

GENITO-URINARY (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ burning /painful urine
☐ unable to hold urine
☐ urgency to urinate
☐ wakes up to urinate
How many times? ___
☐ poor stream/scanty urine
☐ dribbling urine
☐ unable to urinate
☐ frequent urination
☐ sexually active?
☐ diminished sex drive
☐ increased sex drive
☐ impotency
☐ genital itching
☐ genital sores/pain
☐ discharge
☐ history of kidney stones
☐ history of bladder infections
☐ history of prostate problems
☐ history of STD

Color:
☐ cloudy
☐ pale
☐ dark yellow

NEUROPHYSIOLOGICAL (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ history of mental illness
☐ depression
☐ anxiety
☐ easily stressed
☐ confusion/foggy
☐ lack of clarity
☐ moody
☐ fear/fright
☐ hyper
☐ sadness
☐ frustration
☐ melancholy
☐ grieving
☐ easy to anger
☐ irritability
☐ restlessness
☐ emotional
☐ frequent sighing
☐ over-worried
☐ bad-tempered
☐ tics
☐ hopelessness
☐ joyful
☐ giddy
☐ over-thinking
☐ talkative
☐ silent
☐ extrovert
☐ introvert
☐ seizures
☐ panic
☐ feeling stuck
☐ tremors/shaking
☐ convulsions
☐ coma
☐ concussion
☐ paralysis
☐ trauma at birth
☐ vaginal delivery
☐ considered/attempted suicide
☐ unable to focus
☐ phobia
☐ seeing therapist

MEN'S HEALTH (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ prostate problems
☐ decreased libido
☐ hernia
☐ infertility
☐ history of STD .
☐ swellings, lumps and pain in testicles
☐ discharge from penis
☐ cold feeling in genitals
☐ difficult ejaculation
☐ painful erections
☐ difficult achieving and maintaining erection
☐ injury to reproductive organs
☐ sexually active?
☐ other:_____
_____

MUSCULO-SKELETAL (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

Area:
☐ face
☐ jaw
☐ chest
☐ epigastria area
☐ rib cage
☐ low abdominal
☐ pelvic
☐ genitals
☐ neck
☐ shoulder
☐ fingers
☐ upper back
☐ mid back
☐ knee
☐ lower back
☐ tailbone
☐ sciatica
☐ upper limbs
☐ lower limbs
☐ feet
☐ whole body
☐ bone
☐ muscle
☐ joint

Rate the pain: Scale 1-10 (10 worst) 1 2 3 4 5 6 7 8 9 10
Do you often carry heavy objects? ☐ not often ☐ often
How often is the pain present:
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% of the time

Is/does your pain?: ☐ fixed ☐ moves around
☐ radiates ☐ sharp ☐ dull
Is pain aggravated by: ☐ sitting ☐ standing
☐ movement ☐ pressure ☐ warm ☐ cold

Do you have?
☐ pain
☐ swelling
☐ burning
☐ weakness
☐ numbness
☐ tingling
☐ arthritis
☐ pressure
☐ stiffness
☐ spasms
☐ twitching
☐ shaking
☐ soreness
☐ tenderness
☐ unsteadiness
☐ tension
☐ heaviness
☐ better with movement
☐ worse with movement
☐ hernia

GYNECOLOGY AND PREGNANCY (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

Date of last PAP:_____ Last Menstrual Period:_____

Color: ☐ pale red ☐ light red ☐ red ☐ dark red ☐ red/purple ☐ purple ☐ dark purple ☐ brown

☐ pelvic pain
☐ currently sexually active
☐ pregnant currently
☐ # of pregnancies _____
☐ # of live births _____
☐ no. of miscarriages _____
☐ # of abortions _____

☐ # of premature birth _____
☐ length of period _____
☐ age at first menses _____
☐ fibroids
☐ endometriosis
☐ abd. bloating/fullness
☐ spotting between periods

☐ early menstrual cycle(less 21 days)
☐ mood change before period
☐ body change before period
☐ late menstrual cycle (less than 35 days)
☐ infertility
☐ pain during intercourse

☐ irregular menstrual cycle
☐ days of heavy flow _____
☐ uterine prolapsed
Clots: ☐ large ☐ small
Menopause:
☐ post ☐ post

Menstrual pain/cramps: ☐ before ☐ during ☐ after
Vaginal discharge: ☐ odor ☐ no odor ☐ watery ☐ thick ☐ curdy ☐ itchy color: ☐ clear ☐ white ☐ yellow ☐ bloody
Birth control pills: type _____ how long? _____

BREAST (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

☐ history of breast disease
☐ breast lumps/masses
☐ history of breast cancer
☐ breast tenderness
☐ breast fullness/swelling
☐ breast pain

Breast Discharge: ☐ clear ☐ black ☐ white ☐ blood ☐ yellow ☐ watery ☐ thin ☐ thick ☐ warmth ☐ green

INFERTILITY (PLEASE CHECK ALL THAT APPLY TO YOU WITHIN THE LAST 3 MONTHS.)

How long have you been trying to get pregnant? _____
Have you tried any method of assisted reproduction?_____
Any long term exposure to chemicals? _____
Do you keep track of you menstrual cycle? _____
Do you keep your BBT(Basal Body Temperature? _____
Do you test yourself for ovulation?_____
Has your partner been evaluated for infertility?_____
Anything else you would like to tell us?_____

BODYWISE WELLENSS & SPA ~ PATIENT INFORMATION

Name _____ Last 4 digits of Social Security # _____
Birth Date_____ Age_____ Marital Status_____ Gender: M_____ F_____
Address _____ City _____ State _____ Zip _____
Primary Phone Number _____ [ ] Home [ ] Mobile [ ] Work
Secondary Phone Number _____ [ ] Home [ ] Mobile [ ] Work
E-mail address: _____
Place of Employment _____ Occupation _____
Address _____ City _____ State _____ Zip _____
Please list the family members or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:
Name _____ Telephone Number _____
Name _____ Telephone Number _____
Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):
Name _____ Telephone Number _____
Name _____ Telephone Number _____
[ ] I do wish to have this information disclosed.
How were you referred to the Clinic? _____

It is the responsibility of the patient to notify BodyWise Wellness & Spa if any of their information should change. Please inform the front desk of any changes, so that we may update your records.
PRINT Patient Name & DATE _____
Patient Signature _____
.

BodyWise Wellness & Spa
4235 Green Bay Road, Kenosha, WI 53144 - P (262) 652-1418 | E bbodywise@gmail.com

I hereby consent to the following provisions deemed necessary by BODYWISE WELLNESS & SPA:
Patient's Name: (PLEASE PRINT): _____

1. Treatment: Any and all health care and treatment, which may include acupuncture, herbal formulas, TuiNa, cupping therapy, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.
2. Financial information: All professional fees are due in full at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. BODYWISE WELLNESS & SPA does not bill insurance or other third- party payers, I understand that it is my sole responsibility to request reimbursement from my health insurance plan if I desire reimbursement of costs paid.
3. Authorization of Compensation: Payment is made directly to BODYWISE WELLESS & SPA for the amount due after services have been rendered. Payment can be made by major credit cards, cash or check.

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____
(BODYWISE WELLENSS & SPA REPRESENTATIVE)