Waterlily Wellness

acupuncture & chinese herbal medicine

Intake Form

Today's Date: _____ Date of birth: _____

Name: _____

Preferred pronouns: _____ Occupation: _____

Address: _____

City, State, Zip: _____

Phone number: _____ Email: _____

Emergency contact: _____ Phone number: _____

Primary health concerns: Please describe your reason(s) for seeking treatment with us today:

The following questions are voluntary but the information gathered helps us treat you holistically. Please answer only what you feel comfortable to share at this time.

Intake Form

Current medications/supplements:

Current or former hospitalizations, surgeries, major injuries, or trauma (please list what & when)**:**

Health history: Please select any of the following that you've had or currently have:

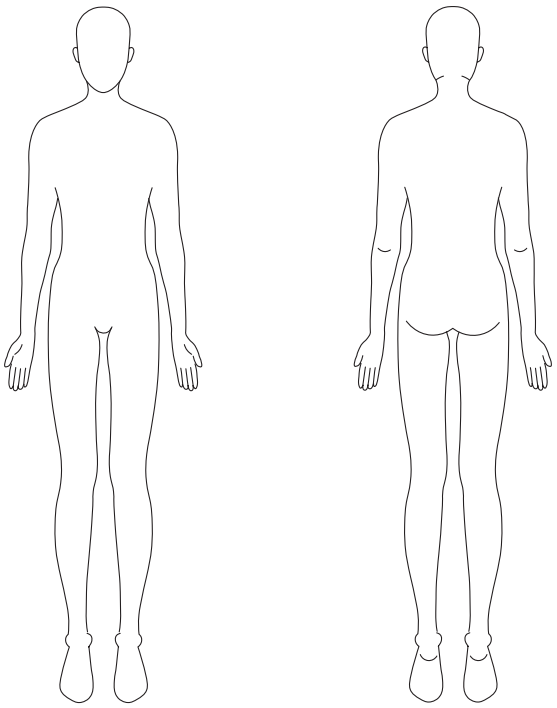
- ☐ Addiction
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Heart disease
- ☐ Hepatitis A/B/C
- ☐ HIV+
- ☐ Long Covid
- ☐ MS
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Tuberculosis

Allergies: _____

_____

Autoimmune disorder: _____

On the diagram below, please indicate the location of your pain:



How severe is your pain? Please circle a number:

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

none *severe*

When did your pain start? _____

_____

How does the pain feel? Please circle what applies:

Burning	Dull	Shooting	Tingling
Sharp	Achy	Stiff	Throbbing

What, if anything, makes the pain better?

_____

What, if anything, makes the pain worse?

_____

Intake Form

Please indicate your energy level over the past 2 weeks:

1—2—3—4—5—6—7—8—9—10

none *plenty*

Sleep

On average, how many hours of sleep do you get per night? _____

- ☐ Difficulty falling/staying asleep
- ☐ Restless sleep
- ☐ Restless leg syndrome
- ☐ Vivid/stressful dreams
- ☐ Not rested upon waking

Emotional & psychological

- ☐ Shy/timid
- ☐ Irritability/easy to anger
- ☐ Anxiety/worry
- ☐ Extreme fear/terror
- ☐ Depression/sadness/cry a lot
- ☐ Considered or attempted suicide

Lifestyle

- ☐ Exercise regularly
- ☐ Eat regularly
- ☐ Drink alcohol (_____ glasses/week)
- ☐ Drink coffee (_____ cups/day)
- ☐ Drink water (_____ cups/day)
- ☐ Smoke cigarettes (_____/day)
- ☐ Use marijuana/CBD regularly
- ☐ Use other recreational drugs
- ☐ Never thirsty
- ☐ Always thirsty
- ☐ Prefer hot drinks
- ☐ Prefer cold drinks
- ☐ Adhere to a special diet:

_____

- ☐ Avoid certain foods:

_____

_____

_____

- ☐ Crave certain foods:

_____

_____

_____

Please describe what you typically eat for meals:

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Intake Form

Digestion

- ☐ Excessive appetite
- ☐ Low appetite
- ☐ Fatigued after meals
- ☐ Reflux/heartburn/ belching
- ☐ Nausea/vomiting
- ☐ Gas/bloating
- ☐ Abdominal/ stomach pain
- ☐ _____ bowel movements every _____ day(s)
- ☐ Bowel movement feels incomplete
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Hemorrhoids
- ☐ IBS

Urinary

- ☐ Frequent urination
- ☐ Wake up _____ times/night to urinate
- ☐ Poor bladder control
- ☐ Burning/pain while urinating
- ☐ Urination feels incomplete
- ☐ Frequent UTIs
- ☐ Kidney stones
- ☐ Kidney disease

Cardiovascular

- ☐ High blood pressure
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Tight chest
- ☐ Edema/swelling

Resipratory

- ☐ Frequent colds
- ☐ Chronic allergies
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Cough

Head/ears/eyes/nose/throat

- ☐ Headaches
- ☐ Migraines
- ☐ Jaw pain
- ☐ TMJ
- ☐ Teeth grinding
- ☐ Ringing in the ears
- ☐ Poor hearing
- ☐ Dizziness
- ☐ Earache/ear infections
- ☐ Floaters (spots in vision)
- ☐ Eye tearing/dryness
- ☐ Red/itchy eyes
- ☐ Sinus congestion
- ☐ Post-nasal drip
- ☐ Phlegm stuck in throat
- ☐ Nose bleeds
- ☐ Mouth/tongue sores
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Recurrent sore throat

Temperature & perspiration

- ☐ Generally tend to feel hot
- ☐ Generally tend to feel cold
- ☐ Cold hands/feet
- ☐ Feel hot in the afternoon
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Spontaneous sweating
- ☐ Sweaty palms/feet

Skin & hair

- ☐ Rash/itching/hives
- ☐ Acne
- ☐ Dry/brittle hair
- ☐ Hair loss
- ☐ Weak/brittle nails
- ☐ Dandruff/dry scalp

Intake Form

If applicable:

Average length of full menstrual cycle: _____ days

Bleeding typically lasts _____ days

Last period started: _____

- ☐ Experience PMS
- ☐ Experience cramps
- ☐ Fatigued with period
- ☐ Clots with periods
- ☐ Endometriosis
- ☐ Heavy periods
- ☐ Irregular cycle
- ☐ Abnormal bleeding
- ☐ Uterine fibroids
- ☐ Ovarian cysts
- ☐ Vaginal dryness
- ☐ Yeast infections
- ☐ Low libido
- ☐ Trying to get pregnant
- ☐ (May be) pregnant
- ☐ Have miscarried

Current method of birth control: _____

Number of pregnancies: _____

Office notes: