Mari Galle Acupuncture, PLLC

Mari Galle, L.Ac

Patient Intake Form

Thank you for visiting Mari Galle Acupuncture. Please take the time to fill out this intake form so we may be able to provide you with a complete evaluation. All your information is confidential. If you have any questions, please ask.

Full name:		☐F ☐M	Date:
Date of Birth:	Age:	Occupation:	
Mobile #	Home #		Work#
Street Address:			
City:	State:	Zip code:	Allow phone contact ☐Yes ☐No
Email address:			Allow email contact ☐Yes ☐No
Emergency contact name & phone #			
Relationship status:			# of children:
Primary Care Physician & phone #			
Chiropractor & phone #			
How did you find out about Mari Galle Acupuncture?			

Main problem(s): _____

What diagnosis, if any, have you received for this problem? _____

When did this problem begin? _____ Does this problem interfere with daily activities? _____

What causes these problems? _____ Is there a family history of this? _____

What kind of treatment have you tried? _____

What makes it worse? _____ What makes it better?_____

Medical History: (please include the month/year when the event occurred or when diagnosis was established)

Surgeries/Hospitalizations: _____

Significant traumas: _____

Allergies: _____

Diagnosis	***Self***	***Family***	***Diagnosis***	***Self***	***Family***	***Diagnosis***	***Self***	***Family***
Cancer/type			Breathing issues			Tuberculosis		
Diabetes			Heart Disease			High Cholesterol		

Hepatitis			Digestive disorder			High BP		
Thyroid Disease			Venereal Disease			Emotional dis.		
Seizures			Alcoholism			Anemia		
Arthritis			Depression			Other		

Medicines (please list type, dosage, and reason):

_____

_____

_____

Occupation: _____ *Mostly:* ☐Indoor ☐Outdoor *Work Stress?* ☐Yes ☐No

Personal: Height: _____ Weight now: _____ Weight 1 year ago: _____

Habits: Do you smoke? ☐Yes ☐No What? _____ How much & how often? _____

Please describe any use of drugs for non-medical purposes: _____

Do you exercise regularly ☐Yes ☐No Please describe your exercise program: _____

How many hours do you sleep on average? _____ What time do you usually go to bed? _____

Diet: How much coffee do you drink? _____cups/day Sodas_____number/day Tea _____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____ How often? _____

How much water do you drink per day? _____ Are you a vegetarian? ☐Yes ☐No ☐Yes, but not strict

Do you eat a lot of spicy food? ☐Yes ☐No

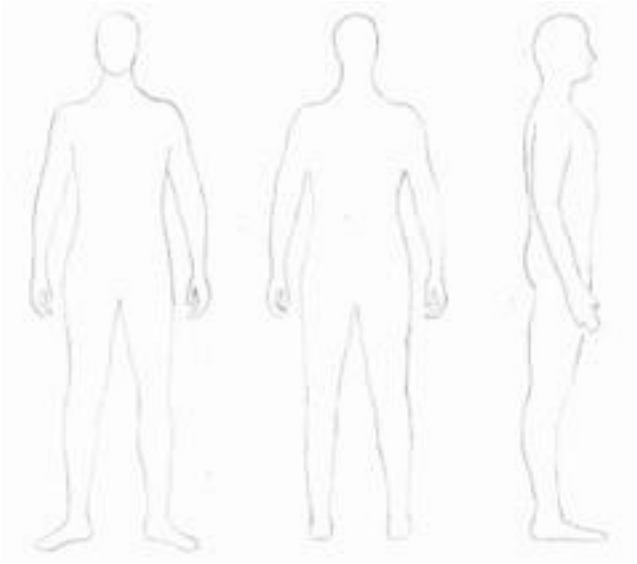
Please describe your average daily diet (be as specific as possible):

Morning _____ Afternoon

_____

Snacks _____

Evening _____



Indicate painful or distressed areas:

Please check if you have or have had (in the last 3 months) any of the following conditions:

General	☐poor appetite	☐poor sleep	☐fatigue	☐fevers	☐chills
☐night sweats	☐sweats easily	☐tremors	☐cravings	☐change in appetite	
	☐bleed/ bruise	☐localized			
☐poor balance	☐weight loss	☐weight gain easily	weakness		
☐peculiar tastes	☐desire hot food	☐desire cold food	☐strong thirst		
☐sudden energy drop (what time of day) _____ Favorite time of year _____ Worst time of year _____					
Skin & Hair	☐rashes	☐ulcerations	☐hives	☐itching	☐eczema
☐hair loss	☐dandruff	☐dry skin	☐recent moles	☐pimples	☐acne
☐purpura	☐change in hair or skin texture		☐other		
Musculoskeletal	☐joint disorders	☐muscle weakness	☐pain/soreness in muscles		☐hernia
☐cold hands/ feet	☐difficulty walking	☐swollen hands/feet	☐back pain	☐spinal curvature	
☐numbness	☐tingling	☐paralysis	☐neck tightness	☐neck pain	
☐shoulder pain	☐hand/wrist pain	☐hip pain	☐knee pain	☐joint sprain	
Head, eyes, ears, nose, and throat		☐dizziness	☐migraines	☐concussions	☐glasses
☐color blind	☐night blindness	☐eye strain	☐eye pain	☐poor vision	☐cataracts
☐blurry vision	☐earaches	☐poor hearing	☐ear ringing	☐spots in front of eyes	
☐sinus issues	☐nose bleeds	☐grinding teeth	☐teeth issues	☐sore throat	
☐facial pain	☐jaw clicks	☐lip/tongue sores	☐difficulty swallowing		☐other

Cardiovascular ☐high blood pressure ☐low blood pressure ☐chest pain ☐palpitations ☐fainting ☐irregular heartbeat ☐varicose veins ☐phlebitis ☐rapid heartbeat ☐other

Respiratory ☐cough ☐coughing blood ☐wheezing ☐difficulty breathing ☐bronchitis ☐pneumonia ☐chest pain ☐production of phlegm: color? _____

Gastrointestinal ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐gas ☐belching ☐black stools ☐blood in stools ☐indigestion ☐bad breath ☐parasites ☐hemorrhoids ☐abdominal pain ☐gallbladder issues ☐rectal pain ☐chronic laxative use

Bowel movements: Frequency _____/day Color _____ Odor _____ Texture/form _____

Neuro-psychological ☐loss of balance ☐lack or coordination ☐concussion ☐depression ☐anxiety ☐stress ☐bad temper ☐bi-polar

Genital-urinary ☐painful urination ☐frequent urination ☐bloody urine ☐urgency to urinate ☐kidney stones ☐dribbling urine ☐pauses in flow ☐frequent urinary tract infection ☐genital pain ☐genital itching ☐genital rashes ☐STD ☐Other _____

Female ☐irregular cycle ☐pain/cramps prior/during cycle ☐endometriosis ☐clots ☐pelvic infection ☐fibroids ☐ovarian cysts ☐fertility issues ☐hot flashes ☐PMS ☐breast lumps ☐breast tenderness ☐frequent vaginal infections ☐vaginal/genital discharge

Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Premature births _____ C-sections _____ Difficult delivery _____

First day of last period _____ Age of first period _____ Duration of period _____ days, Cycle _____ days

Do you practice birth control? ☐Yes ☐No If yes, what type and for how long? _____

If you take birth control pills, what Rx are you taking and for how long? _____

Male	☐prostate problems	☐discharge	☐erectile dysfunction	☐other
☐frequent seminal emissions		☐ejaculation problems	☐painful/swollen testicles	☐fertility problems

Are there any other health issues you want to discuss with us?

I have completed this form correctly to the best of my knowledge.

_____ _____

Signature ☐Adult patient ☐Parent/Guardian ☐Spouse ***Date***

Cancellation Policy: Treatments are by appointment only. There is a 24-hour cancellation policy. We reserve the right to charge a $30 fee for an appointment canceled with less than 24-hour notice or for a "no show" appointment. Cancellations should phoned-in by calling 608-574-3799. Should Mari Galle Acupuncture be unable to treat due to inclement weather or other extenuating circumstances, Mari Galle Acupuncture will not charge patients for that day's appointments.

I have read the above Cancellation policy and agree to the terms.

_____ _____

Signature ☐Adult patient ☐Parent/Guardian ☐Spouse ***Date***