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Wax and Wane Wellness LLC - Kelly Sherman L.Ac., CHN

**New Patient Health History + Initial Intake**

Legal Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred gender + Pronoun\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you prefer phone or email contact?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact relationship to you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a Primary Care Physician? Yes No

If yes, please provide the doctor’s name and clinic name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Kelly Sherman L.Ac., CHN / Wax and Wane Wellness? Please circle one below:

* Wax and Wane Wellness Website/ Instagram/ Facebook?
* Bod Wellness Collective Website/Instagram/Facebook?
* Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your most important health concerns/areas you’d like to focus on during our visits? **Please list in order of importance.**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Information**

Significant Traumas (auto accidents, falls, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking or have taken within the past 2 months and the reason for taking them:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies? If yes, what kind?

Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foods\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmentals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History:** Please circle any conditions or symptoms you have now or ever have had.

|  |  |  |  |
| --- | --- | --- | --- |
| Arthritis  Heart Attack  Cancer  Ulcer  Chronic Fatigue  Alcoholism  Gastritis/ Pancreatitis | Liver/Gallbladder Dz.  Hypo/Hyperglycemia  Diabetes  Autoimmune Disorder  Anemia  Eating Disorder  Epilepsy/Seizures | Stroke  Kidney Dz/ stones  Impotence  Hepatitis  Thyroid Imbalance  Chronic Pain  Prolapsed Organ | Heart Disease  High Cholesterol  Diverticulitis  Raynaud’s Disease  Blood Clotting Disorder  HIV+  Emphysema  Fainting |

Do you have a pacemaker? Y N

Any other serious health conditions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Circle if you currently have or have had any of these conditions below in the last 6 months:**

**General**

|  |  |  |  |
| --- | --- | --- | --- |
| Poor Appetite  Chills  Cravings  Bleed/Bruise easily  Muscle weakness/fatigue | Poor Sleep  Night Sweats  Localized Weakness  Weight loss  Weight gain | Fatigue  Sweat Easily  Poor Balance  Peculiar taste in mouth  Hot flashes | Sudden energy drop  Change in appetite  Fevers  Tremors  Dental/gum problems |

**Skin and Hair**

|  |  |  |  |
| --- | --- | --- | --- |
| Rashes  Eczema/Psoriasis  Skin discoloration  Greasy hair  Dry hair | Ulcerations  Dandruff  Acne  Warts  Oils skin | Hives/Allergic Dermatitis  Loss of hair  Change in skin/hair texture  Fungal infection  Dry skin | Itching  Recent moles  Face flushing  Weak nails  Ridged nails  Redness of skin |

**Head, Eyes, Ears, Nose, and Throat**

|  |  |  |  |
| --- | --- | --- | --- |
| Sinus Pain  Eye Strain  Dark circles under eyes  Ringing in ears  Nose bleeds  Sores on lips/tongue  Headaches | Difficulty swallowing  Eye pain  Eye dryness/itchiness  Cataracts  Poor hearing  Recurrent sore throat  Recurrent colds | Migraines  Poor vision  Blurred vision  “Floaters” in sight  Grinding teeth  Jaw clicks/locks | Glasses/contacts  Poor night vision  Earaches  Sinus congestion  Frequent sneezing  Frequent runny nose |

**Cardiovascular**

|  |  |  |  |
| --- | --- | --- | --- |
| Chest pain/ pressure  Cold hands/ feet  Shortness of breath  Heart murmur | Irregular heart beat  Swelling of hands/ feet  Varicose veins  Spontaneous sweating | Palpitations at rest  Blood clots  Pressure in chest  dizziness | Spider veins  Phlebitis  High blood pressure  Low blood pressure |

**Respiratory**

|  |  |  |  |
| --- | --- | --- | --- |
| Cough/ wheezing  Pneumonia | Coughing up blood  Pain with deep inhalation | Tightness in chest | Asthma |

**Gastrointestinal**

|  |  |  |  |
| --- | --- | --- | --- |
| Nausea  Gas  Indigestion  Bloating  Gurgling  IBS  Excessive hunger | Vomiting  Belching  Bad breath  Strong smelling stools  Acid reflux/ GERD  Frequent hiccoughing  “Sour” stomach | Diarrhea  Black stools  Rectal/anal pain  Loose stools  Hernia  Crohn’s Disease | Constipation  Blood/mucus in stools  Hemorrhoids  Abdominal pain/cramps  Sticky stools  Food in stools |

**Urinary**

|  |  |  |  |
| --- | --- | --- | --- |
| Pain with urination  Unable to hold urine  Impotence | Frequent urination  Cloudy urine  Sores on genitals | Blood in urine  Scanty urine flow  Dribbling after urination  Urinary Tract Infection(s) | Urgent urination  Copious flow of urine  Burning urination  Concentrated urine |

**Musculoskeletal**

|  |  |  |  |
| --- | --- | --- | --- |
| Neck pain  Knee pain  Hip pain  Back pain: low, mid, upper? | Shoulder pain  Frequent sprains/strains  Muscle pain/tension  Hand/ wrist pain  Sciatica | Heaviness of limbs  Heaviness of head  Rib side pain  Facial pain | Jaw pain/ TMJD  Areas of numbness  Heel pain  Foot/ankle pain |

**Neuropsychological**

|  |  |  |  |
| --- | --- | --- | --- |
| Poor concentration  Lack of coordination  Anxiety  Panic attacks  nervousness | Loss of balance  Poor memory  Memory loss  Bad temper/ rage | Vertigo  Concussion  Easily stressed  Bipolar | ADD/ADHD  Depression  Seasonal affective disorder  Irritability |

**For Men**

|  |  |  |  |
| --- | --- | --- | --- |
| Premature ejaculation  Nocturnal emission  Penal discharge | Fatigue after ejaculation  Pain in testicles  Varicocele | Prostatitis  Testicular mass | Infertility  STD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Gynecological/ Reproductive (For Women)**

|  |  |  |
| --- | --- | --- |
| Difficult/Painful Intercourse  Vaginal dryness  Vaginal sores  Vaginal discharge  Vaginal itching/burning  Frequent vaginal infections  Irregular menstruation  Pelvic adhesions/scarring  Pelvic pain  Breast pain | Ovarian cysts  Endometriosis  Uterine fibroids/polyps  Fibrocystic breast tissue  Polycystic Ovarian Syndrome  Nipple discharge  Pelvic/tubal infection  Infertility  STD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of last PAP \_\_\_\_\_\_\_\_\_\_\_\_  Abnormal PAP? When?\_\_\_\_\_\_\_  Number of Pregnancies \_\_\_\_\_\_\_\_  Number of Births\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Age of first menses\_\_\_\_\_\_\_\_\_\_\_

Date of last menses\_\_\_\_\_\_\_\_\_\_\_\_ Recent menstrual changes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience spotting between periods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have PMS symptoms? Pain, Irritability, Fatigue, Anxiety/Depression?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use birth control? \_\_\_\_\_\_\_\_ What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If currently pregnant, how far along?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you attempting pregnancy currently? If so, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other menstrual or reproductive concerns?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional Evaluation**

List some of your favorite foods or foods that you crave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any known food sensitivities, allergies or foods that otherwise disagree with you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any kind of special diet or adhere to a particular food philosophy? yes / no…. Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use:**

Alcohol? yes / no

Tobacco? yes / no

Recreational drugs/medications? yes / no

How many glasses of water do you drink a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you react to any chemicals, cosmetics, household cleaners, smoke, fabrics, etc? \_\_\_\_\_\_\_\_\_\_\_\_

If yes please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Evaluation**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your hobbies/interests? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you say are your main stressors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale from 1 – 10 (1 being none and 10 being very extreme) what is your current level of stress? \_\_\_\_\_\_

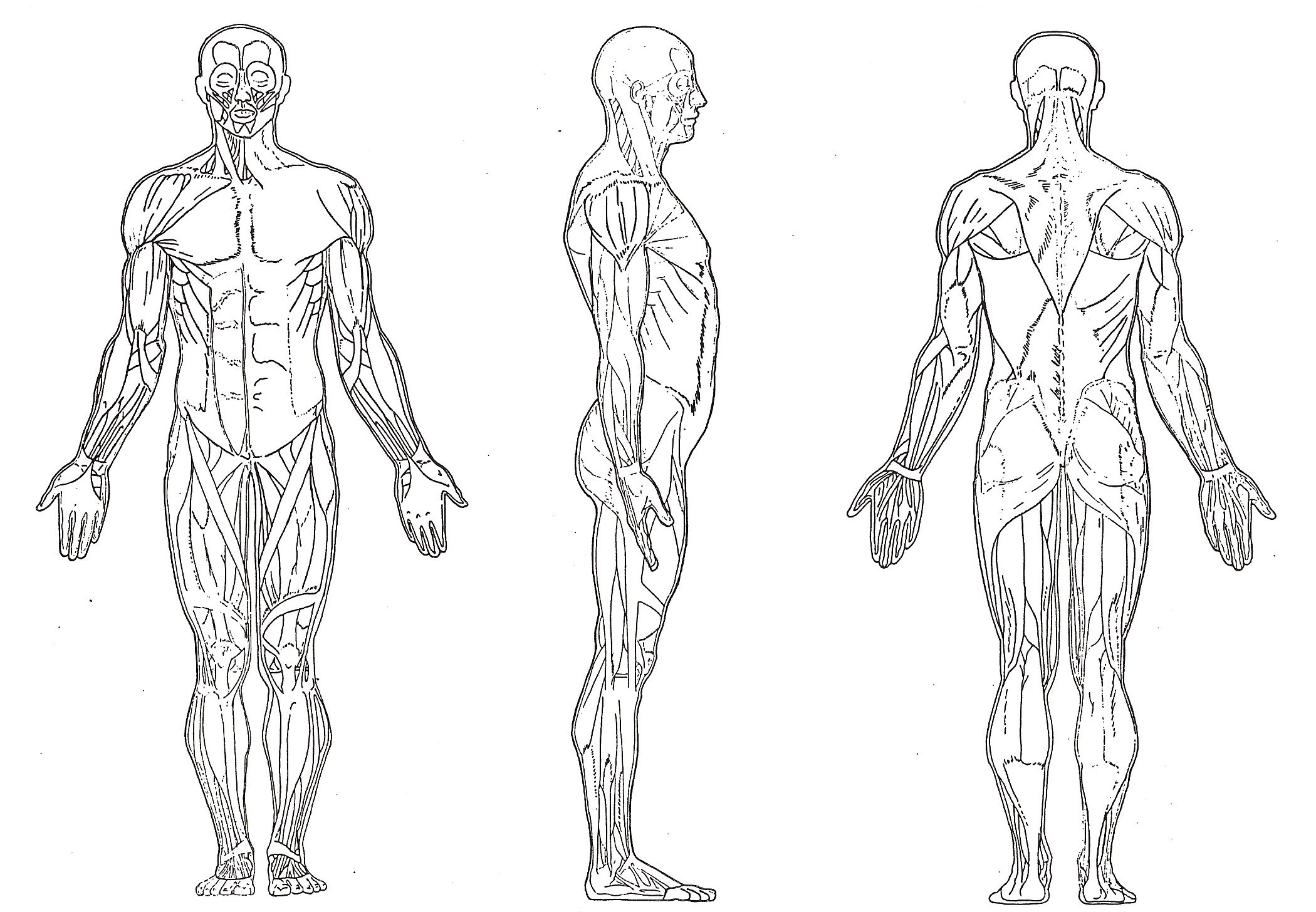
Is your energy level: \_\_\_ high \_\_\_ low \_\_\_ up and down?

What do you do for exercise?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sleep at night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual time you get up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you feel rested when you get up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE MARK YOUR AREAS OF CONCERN**

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Consents and Acknowledgement: Full length forms available to review at www.waxandwanewellness.com

1)I have carefully read, understand, and give my consent for Acupuncture and Classical Chinese Medicine treatment from Kelly Sherman L.Ac. of Wax and Wane Wellness LLC. I understand that I may ask my practitioner for a more detailed explanation at any time.

2) I have been given an opportunity to read and I acknowledge and agree to Wax and Wane Wellness LLC’s Privacy and Sharing of Information Policy as required by HIPAA.

3) I acknowledge Wax and Wane Wellness LLC’s recommendation in accordance with Virginia law for examination by a physician in conjunction with my acupuncture care.

4) I have read and agree to the Wax and Wane Wellness LLC @ Bod Wellness Collective Office Policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient (or Representative\*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient Representative\*

\* **Note:** Patient Representative should sign if patient is a minor, or otherwise unable to sign for him or herself.