Shelly Wagar Acupuncture
1829 NE Alberta St, Suite A | Portland . OR . 97211 | 503-422-9103

WELCOME TO MY PRACTICE

INTAKE FORMS: Please fill out the intake form completely as some conditions have particular contra-indications to bodywork or acupuncture modalities. Your response to acupuncture or shiatsu will depend on your current health status and each session is structured to meet your unique treatment needs.

APPOINTMENTS: Please call 503-422-9103 to schedule appointments. Texting is great too! Keep in mind the broader benefits of treatment are cumulative. When first receiving acupuncture or bodywork, it is best to receive a series of consecutive sessions no more than 2 weeks apart for your body to hold changes and prevent relapse into old patterns. After you feel you are holding change and/or healing, monthly appointments are recommended for overall health maintenance. Your practitioner will discuss your individual treatment needs with you at your appointment.

PAYMENT: Payment is required on the day of you appointment. Cash, check, and credit cards are accepted. In the event that your check is returned, a $20 fee will be added to your next visit. I can bill most health insurance companies as Out of Network practitioner. Please check your policy for your out of network acupuncture treatment benefits.
I do bill auto insurance for Motor vehicle accidents.

CANCELLATIONS: We require 24 hours advance notice if you need to cancel your appointment. Please note a $65 fee is charged for same day cancellations. **FULL FEE** for missed appointments, *except in the case of inclement weather or Covid-19 symptoms*. If you cannot make it to your appointment, you may send a friend (someone who is already a patient in the clinic) in your place. Thank you for respecting this policy!

GIFT CERTIFICATES: Treat your friend, colleague, or family member to a session! Gift certificates are available for one-hour session rates.

Thank you for coming to me for your healthcare needs!
I look forward to supporting you in your healing path!

CONFIDENTIAL INTAKE FORM

Date:

Legal Name: _____Date of Birth: _____/_____/_____

Age: _____

Preferred Name: _____ Preferred Pronoun _____ Occupation_____

Address: _____City_____ State_____Zip_____

Email _____Phone: _____ Ok to leave messages? Y/N

How did you hear about our clinic? Emergency Contact: _____

_____ Phone: _____Relationship: _____

Primary Care Provider: _____ Phone: _____

Please explain your current HEALTH CONCERNS that you would like to address in our treatments:

1)_____

2)_____

3)_____

Y/N Do you have any medical conditions or infectious diseases that have been diagnosed by a physician?

Please describe:

_____

Have you ever received any of the following healthcare treatments? (circle all that apply):

Acupuncture Shiatsu Massage Chiropractic Osteopathic Naturopathic Physical Therapy Other _____

For what reason(s)?

Please list any **Major Illness, Injury, Surgery or Accident** you have experienced. Include dates.

_____

_____

_____

X-Rays / CAT Scans / MRIs / NMRs ?

_____

_____

_____

Please list all medications, vitamins, and/or supplements you are currently taking with reasons:

_____ _____

_____ _____

_____ _____

_____ _____

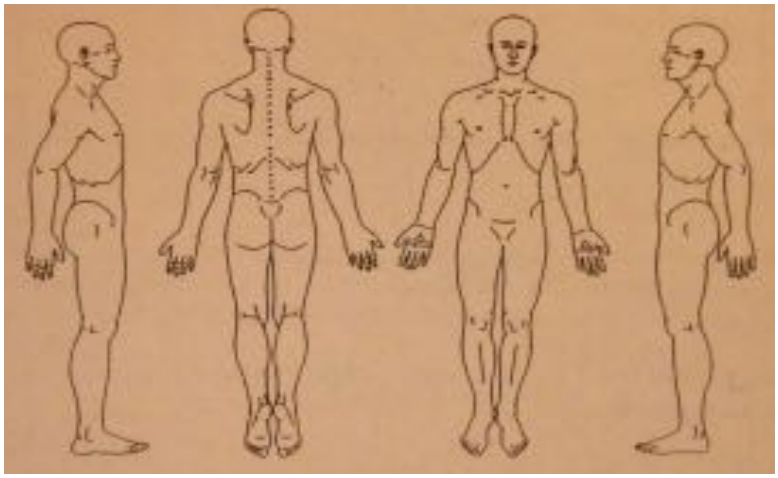
_____ _____

CIRCLE conditions you are experiencing NOW / UNDERLINE all you have experienced in the PAST

Neck / Shoulder Pain Arm Pain Leg Pain Muscle Spasms / Cramps Joint Pain Tendonitis

Back Pain: Upper / Mid / Low Head Injuries Osteoporosis Broken/Fractured bones (which ones?) _____

Please indicate on the diagrams below any areas you are *currently* experiencing Discomfort (D), Pain (P), Numbness (N), or Tingling (T):



Y/N Do you have any ailments that are restricting you from performing daily tasks? _____

If yes, what do you have trouble accomplishing? _____

Where in your body do you hold stress? _____

LIFESTYLE:

Living Situation (circle): single with roommates/family with spouse / partner

with children—how many? _____ ages _____

Circle your typical diet: Omnivore Vegetarian Vegan Special Diet (list) _____

Y/N Do you have any food sensitivities or allergies? If yes, please list:

_____

Y/N Do you regularly drink Water? How many cups / day ? _____

Y/N Do you consume Caffeine? Type & Amount _____

Y/N Do/Did you use Tobacco? If yes, How often? _____When did you Quit?_____

Y/N Do you use Alcohol or Recreational Drugs? Type & Frequency?

_____

Y/N Do you sleep well during the night? How many hours per night do you sleep? _____

Y/N Do you wake feeling rested?

Y/N Do you have difficulty falling or staying Asleep?

Y/N Do you Exercise? Activities/How often?

_____

What do you do to relax and reduce stress?

_____

*

HEALTH HISTORY: CIRCLE Current conditions / UNDERLINE Past conditions

EYES/EARS/NOSE/THROAT

Impaired Vision
Eye Pain / Strain
Glasses / Contacts
Tearing / Dryness
Glaucoma
Headaches
Head Injury
Hearing Problems
Ear Ringing
Earaches
Sinus Problems
Allergies/Hay Fever
Nose Bleeds
Loss of Smell
Frequent Sore Throats
TMD / Jaw Problems

RESPIRATORY

Pneumonia
Frequent Common Colds
Difficulty Breathing
Shortness of Breath
Persistent Cough
Asthma
Emphysema
Pleurisy
Tuberculosis

ENERGY/IMMUNITY

Fatigue
Slow Wound Healing
Chronic Infections
Chronic Fatigue Syndrome

EMOTIONAL

Mood Swings
Nervousness / Irritability
Anxiety / Depression
Other: _____

NEUROLOGIC

Numbness / Tingling
Paralysis
Vertigo / Dizziness
Seizures / Epilepsy

CARDIOVASCULAR

High/Low Blood Pressure
Chest Pain
Swelling of Ankles
Palpitations/Fluttering
Heart Attack

Stroke
Irregular Heartbeat
High Cholesterol
Congestive Heart Failure
Varicose Veins
Blood Clots

GASTROINTESTINAL

Changes in Appetite
Nausea/Vomiting
Heartburn / Acid Reflux
Mouth sores
Ulcers
Belching / Passing Gas
Abdominal Pain
Gall Bladder Disease / Stone
Liver Disease
Hepatitis
Hemorrhoids
Constipation / Diarrhea
Black/Clay/ Bloody Stools

ENDOCRINE

Diabetes (Type Hypoglycemia
Hypothyroid
Hyperthyroid
Night Sweats
Feeling Hot / Cold

GENITO-URINARY TRACT

Kidney Disease
Kidney Stones
Painful Urination
Frequent UTI
Frequent Urination
Urinary Incontinence
Impaired Urination
Blood in Urine

OTHER

Cancer (Type) _____
Autoimmune Disease (Type)
_____
Bruising Easily
Cold Hands / Feet
Anemia
Weight gain / Loss
Sleep Disorders _____

MALE REPRODUCTIVE:

Sexual Difficulties
Prostrate Problems
Testicular Pain / Swelling Penile
Discharge

FEMALE REPRODUCTIVE

Do you have any reason to believe you may be pregnant? Y / N
If so, how far along?
_____
Irregular Cycles
Heavy Flow
Painful Periods
Clotting
Vaginal Discharge
Premenstrual Problems
Bleeding Between Cycles
Menopausal Symptoms
Difficulty Conceiving
Breast Lumps / Tenderness
Nipple Discharge

Menstrual & Birthing History:

Age of First Menses:_____
Date of Last Period_____
Period Length: _____
Days Between Periods:_____
Birth Control Type:_____
# of Pregnancies: _____
# of Live Births: _____
# of Miscarriages: _____
# of Abortions: _____

List any significant **Family Health History** that may impact your health: (cancer, stroke, etc)

_____

_____

The above health information is accurate and complete to my knowledge.

Signed _____ Date _____

FINANCIAL AND CANCELLATION POLICY

Payments: Payment is due at the time of service, unless prior arrangements have been made. We accept cash, card, or checks.

Insurance: I can bill insurance as an Out of Network provider for acupuncture services. You are responsible for all co-pays and deductibles, as well as any visits not covered by your insurance company.

Cancellations: Please give 24 hours notice by phone when cancelling or rescheduling your appointment. Fee for late cancellation is $65. No shows will be charged for the full amount of your appointment. You may send a friend in your place if they have been in to see us before.

*Currently we are not charging last minute cancellation fees *if it is due to COVID-19 symptoms.*

I understand the above policies:

Signature:

Date: