Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to Wagner Integrative Health!

We are happy that you have chosen us for your care. We can’t wait to work with you to reach your health goals.

Please complete the following intake form and bring it with you to your first appointment. If you have a telehealth appointment, please email this form and any labs done in the past year to clinic@wagnerintegrativehealth.com before your appointment.

If you have extensive medical records from an outside organization, please bring those records and lab results with you to your appointment or have them faxed to us at 920-425-4955.

*Please bring all non-prescription pills and supplements, as well as this completed intake form, with you to your first appointment.*

Your provider sets aside approximately 60 minutes for their first visit with you. If you need to reschedule, call 920-327-7056. Per our Cancellation/No Show policy, cancellations must be made with greater than 24 hour’s notice to avoid a fee.

Please be prepared to pay for the visit at the time of check-in. The cost of the evaluation will be $550. You will be provided a Superbill at the end of your visit to submit to your insurance if you choose. The CPT code for the evaluation will be 99205.

We look forward to meeting you,

****

Patient Intake Form

**Please complete this confidential form to the best of your ability. All questions are optional, skip any parts that are not applicable to your child. The more you share, the better we can help you.**

How did you hear about Wagner Integrative Health? Circle one.

|  |  |  |  |
| --- | --- | --- | --- |
| *Social media* | *Email List* | *Friend* | *Family* |
| *Spouse* | *Event* | *Doctor/Referral* | *Self* |

What are your goals and expectations of this visit?

|  |
| --- |
|  |
|  |
|  |

If your child is not feeling well, when was the last time they felt well? Did something trigger this change in health?

|  |
| --- |
|  |
|  |

Please list any additional symptoms your child is experiencing.

|  |
| --- |
|  |
|  |
|  |

Medical/Physical History

Primary Care Doctor/Facility:

|  |
| --- |
|  |

List any medical problems/illnesses:

|  |
| --- |
|  |
|  |

List any hospitalizations or surgeries your child has had:

|  |
| --- |
|  |

List any mental health/psychiatric conditions:

|  |
| --- |
|  |

List any medications or supplements your child is taking and bring all supplements to your first appointment:

|  |
| --- |
|  |
|  |

Please list any allergies or reactions to foods, medications, or environmental allergies.

|  |
| --- |
|  |
|  |

Family History

Please comment on any serious illnesses, genetic disorders, or other major health conditions that affect your:

Mother:

Maternal Grandmother:

Maternal Grandfather:

Father:

Paternal Grandmother:

Paternal Grandfather:

Other relevant family history:

Childhood Illnesses:

|  |  |  |  |
| --- | --- | --- | --- |
| *Chicken Pox* | *Scarlet Fever* | *Mononucleosis* | *Measles* |
| *Mumps* | *Rubella* | *Rheumatic Fever* | *Ear Infections* |
| *Strep Throat* | *Tonsillitis* | *Pneumonia* |  |

How have you been approaching vaccinations with your child?

|  |  |
| --- | --- |
| *Up to date, following a traditional**CDC vaccine schedule* | *Missing a few, but following a traditional CDC vaccine schedule* |
| *Completing an alternative vaccine**schedule* | *No vaccinating at this time* |

They have received the following vaccines:

|  |  |  |  |
| --- | --- | --- | --- |
| *Measles* | *Mumps* | *Rubella (MMR)* | *dTaP, tDaP or Td (Tetanus)* |
| *Polio* | *Varicella (Chicken Pox)* | *Hepatitis B Pneumococcal (PCV)* | *Haemophiles* |
| *Influenza B(HiB)* | *Influenza Hepatitis Yellow Fever* | *Menigococcal* |  |

Review of Systems

Please check any of the following affecting your infant/child:

|  |  |  |
| --- | --- | --- |
| ***NEUROLOGICAL*** | ***SKIN AND HAIR*** | ***MENTAL*** ***AND*** ***EMOTIONAL*** |
| Paralysis |  | Eczema Rashes or hives  |  | History of trauma or abuse |  |
| Numbness, tingling |  | Changes in skin color |  | Poor concentration, inattention or ADD |  |
| Vertigo/dizziness  |  | Acne or boils  |  | Hyperactivity or ADHD |  |
| Muscle weakness |  | Lumps or bumps on skin |  | Severe mood swings |  |
| Tremors |  | Dry skin |  | ***GASTROINTESTINAL*** |
| Loss of balance or coordination |  | Noticeable hair loss or thinning |  | Nausea |  |
| ***ENDOCRINE*** | ***RESPIRATORY*** | Vomiting  |  |
| Fatigue |  | Cough, asthma, or wheezing |  | Heartburn, reflux, or indigestion |  |
| Overweight |  | Coughing up blood |  | Abdominal pain or cramps |  |
| Underweight |  | History of bronchitis/pneumonia |  | Belching |  |
| Unexplained weight loss |  | Shortness of breath |  | Flatulence |  |
| Unexplained weight gain |  | Shortness of breath lying down |  | Black stools  |  |
| Hypoglycemia (low blood sugar) |  | Chronic Bronchitis |  | Blood in stools |  |
| Cannot function if they skip a meal |  | History of tuberculosis |  | Mucus in stools (looks like snot) |  |
| Excessive hunger |  | ***NECK*** | Bowel movements, how often: |  |
| Excessive thirst |  | Pain or stiffness in neck |  | ***MOUTH AND THROAT*** |
| Often feel colder than others |  | Lumps in neck or goiter |  | Frequent sore throat |  |
| Often feel hotter than others |  | ***HEAD*** | Teeth grinding, clenching, or TMJ |  |
| Diabetes |  | Headaches |  | Pain or difficulty swallowing |  |
| Hypothyroidism  |  | Migraines |  | ***MUSCULOSKELETAL*** |
| Hyperthyroidism |  | History of head injury |  | Joint pain or stiffness |  |
| ***EARS*** | ***URINARY*** | Juvenile Arthritis |  |
| Recurrent ear aches |  | Bed wetting  |  | History of broken bones |  |
| Recurrent ear infections |  | Pain with urination |  | Weakness Muscle spasms or cramps |  |
| Impaired hearing |  | Frequent urinary tract infections  |  | ***CARDIOVASCULAR*** |
| Ringing in ears |  |  | Murmur |  |
| ***EYES*** | ***NOSE AND SINUS*** | Fainting |  |
| Impaired vision |  | Frequent colds/flus |  | ***BLOOD*** |
| Double vision |  | Stuffiness or sinus problems |  | Anemia |  |
| Frequent Tearing  |  | Nose bleeds |  | Easy bleeding or easy bruising |  |
| Blurry vision |  | Loss of smell |  | Cold hands/feet |  |
| Dryness |  | Hay fever/chronic Rhinitis |  | Hemorrhoids |  |

What is your infant’s/child’s general disposition?

|  |
| --- |
|  |
|  |

Diet

If your child is regularly eating solids, please describe their typical diet. Include 2-3 things they eat often for breakfast, lunch, and dinner.

*Breakfast*

|  |
| --- |
|  |
| *Lunch* |
|  |
| *Dinner* |
|  |
| *Snacks* |

Amount of water per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Intolerances or foods they avoid:

|  |
| --- |
|  |
|  |

Servings of veggies they have daily (serving=size of palm)? **0-1 // 1-2 // 3-5 // 5+**

Servings of fruit they have daily (serving=size of palm)? **0-1 // 1-2 // 3-5 // 5+**

Caffeine (including soda, coffee, energy drinks):

|  |
| --- |
|  |

Social History

Parents (If applicable): **Married // Separated // Divorced**

Parent(s), Caregiver(s), or Guardian(s) occupation(s):

|  |
| --- |
|  |
|  |

Others residing in home (including siblings):

|  |
| --- |
|  |
|  |

Patient is currently in: **Daycare // Preschool // School // Home School**

What type of exercise does your child get?

|  |
| --- |
|  |

Does your child smoke? **Yes // No**

Does your child take recreational drugs? **Yes // No**

Does your child wear a seatbelt or use an age-appropriate booster seat /carseat? **Yes // No**

Does your child wear a bike helmet? **Yes // No**

Is your child sexually active? **Yes // No**

*Females only*

Age of first menses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Periods last how many days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periods occur how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last menses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding is? **Heavy // Moderate // Light**

Any concerns about symptoms before or during their period?

|  |
| --- |
|  |

History of pregnancy? **Yes // No**

Are there any other health concerns you would like to discuss? Please explain.

|  |
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*If you have additional questions while filling out this form, please contact us at: 920-327-7056*

*For more information and what to expect during your visit, our practice, and our programs, please visit:* [*www.wagnerintegrativehealth.com*](http://www.wagnerintegrativehealth.com)