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](mailto: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 you or 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?

|  |
| --- |
|  |
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|  |

Medical/Physical History

Primary Care Doctor/Facility:

|  |
| --- |
|  |

List any medical problems/illnesses/surgeries:

|  |
| --- |
|  |
|  |

List any medications you are taking:

|  |
| --- |
|  |
|  |

List any supplements you are taking and bring all supplements to your first appointment:

|  |
| --- |
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|  |

Please list any allergies:

|  |
| --- |
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|  |

Family History

Please list any serious illnesses, cancer, genetic disorders, or other major health conditions that run in your family:

Female Reproductive/Sexual History

Do you identify as:   
☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been pregnant and if so, how many pregnancies, births, miscarriages, and/or abortions have you had?

|  |
| --- |
|  |

Any menstrual or post-menopausal concerns?

|  |
| --- |
|  |

Are you satisfied with your current sex life/sexuality?

|  |
| --- |
|  |

Do you have any problems with libido, orgasm, or any other sexual difficulties?

|  |
| --- |
|  |

Male Reproductive/Sexual History

Do you identify as:   
☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any of the following that apply to you:

|  |  |  |
| --- | --- | --- |
| *Penile discharge or sores* | *Testicular masses or pain* | *Prostate disease* |
| *Increased frequency or urgency to urination* | *Difficulty reaching orgasm* | *Hernias* |
| *Forked stream or dribbling with urination* | *Premature ejaculation* | *Low libido* |
| *Waking more than once per night to urinate* | *Difficulty maintaining an erection* | *Pain* |

Are you satisfied with your current sex life/sexuality?

|  |
| --- |
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|  |

Mind/Emotional Well-being

Would you describe your mood as stable? Why or why not?

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| --- |
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|  |

Please list any major traumatic or life changing events (emotional, verbal, physical or sexual) you have experienced:

|  |
| --- |
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|  |

Spiritual History

Is there anything we should know about your spirituality or religion related to your medical care:

|  |
| --- |
|  |

Symptom Review

Check **Yes** for a condition/symptom you currently have. Check **Past** for a condition/symptom you do not have currently, but it was a significant symptom in the past

| **Symptoms** | **Yes** | **Past** |  | **Symptoms** | **Yes** | **Past** |
| --- | --- | --- | --- | --- | --- | --- |
| **General** |  |  |  | **Cardiovascular** |  |  |
| Cold Intolerance |  |  |  | *Chest pains* |  |  |
| Fatigue |  |  |  | *Shortness of breath* |  |  |
| **Head, Ears, Eyes** |  |  |  | *High blood pressure* |  |  |
| Abnormal smell or taste |  |  |  | *High pulse or irregular pulse* |  |  |
| Ear fullness/ringing |  |  |  | *Palpitations* |  |  |
| Eye irritation, redness, or drainage |  |  |  | *Swollen ankles/feet* |  |  |
| Hearing loss |  |  |  | **Urinary** |  |  |
| Headaches |  |  |  | *Bed wetting* |  |  |
| Sensitivity to light or noise |  |  |  | *Hesitancy* |  |  |
| Vision Problems |  |  |  | *Frequent infections* |  |  |
| **Musculoskeletal** |  |  |  | *Leaking or incontinence* |  |  |
| Back pain/spasm |  |  |  | *Urgency* |  |  |
| Calf cramps |  |  |  | **Digestion** |  |  |
| Joint pain |  |  |  | *Bloating* |  |  |
| Joint redness/swelling |  |  |  | *Blood in stool* |  |  |
| Muscle aches |  |  |  | *Belching* |  |  |
| Muscle spasms |  |  |  | *Excessive flatulence* |  |  |
| Muscle weakness |  |  |  | *Constipation* |  |  |
| **Mood/Nerves** |  |  |  | *Diarrhea* |  |  |
| Fear of leaving the house |  |  |  | *Heartburn* |  |  |
| Anxiety |  |  |  | *Food intolerance* |  |  |
| Depression |  |  |  | *Abdominal pains* |  |  |
| Difficulty concentrating |  |  |  | *Mucous in stool* |  |  |
| Memory issues |  |  |  | *Nausea* |  |  |
| Irritability |  |  |  | *Sore Tongue* |  |  |
| Paranoia |  |  |  | *Vomiting* |  |  |
| Suicidal thoughts |  |  |  | *Strong stool odor* |  |  |
| **Hair, Skin, Nails** |  |  |  | Undigested food in stool |  |  |
| Brittle nails |  |  |  | Bad breath |  |  |
| Hair loss |  |  |  | **Reproductive/Genitalia - Women** |  |  |
| Dry scalp |  |  |  | Breast cysts/lumps |  |  |
| Dry skin |  |  |  | Breast tenderness |  |  |
| Acne |  |  |  | Ovarian cysts |  |  |
| Easy bruising |  |  |  | Low libido |  |  |
| Redness |  |  |  | Endometriosis |  |  |
| **Respiratory** |  |  |  | Infertility |  |  |
| Cough |  |  |  | Vaginal discharge |  |  |
| Allergies |  |  |  | Vaginal pain |  |  |
| Hoarseness |  |  |  | PMS |  |  |
| Nosebleeds |  |  |  | Menstrual irregularity |  |  |
| Nasal congestion |  |  |  | **Reproductive/Genitalia - Men** |  |  |
| Sinus infections |  |  |  | Penile discharge |  |  |
| Snoring |  |  |  | Pain with urination |  |  |
| Wheezing |  |  |  | Difficulty with erection |  |  |
|  |  |  |  | Testicular swelling/tenderness |  |  |
|  |  |  |  | Breast swelling |  |  |
|  |  |  |  | Low libido |  |  |
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|  |  |  |  |  |  |  |

List any additional information you would like to share with your provider today.

|  |
| --- |
|  |

*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)