Soulshine Acupuncture

6025 Taylor Road, Unit 103
Punta Gorda, Florida 33950
(941) 205-8649

New Patient Intake Form

Today’s Date
Full Name
Date of Birth
Email
Phone Number
Street Address
City
State
Postal Code
Country
Emergency Contact Name, Phone Number, and Their Relationship to You
Primary Physician and Telephone Number
Occupation/Employer/School
Is this your first time getting acupuncture?
How did you find Soulshine Acupuncture?

Primary Health Concerns

Please describe the TOP THREE HEALTH ISSUES you would like to address. When did these issues start and what treatments have you tried? Please list any alleviating or aggravating factors.

1.

2.

3.

Medications/Supplements

Please list all current medications and supplements, both prescription and over-the-counter, and the date when you started taking it. If none, please indicate.

Allergies/Nutrition

Please list any known allergies or food sensitivities. If none, please indicate.

Please list any special diet you have (low carb, vegan, vegetarian, gluten-free, etc.)

Social History

Do you use any of the following substances?

☐ Coffee	☐ Cannabis/Marijuana
☐ Alcohol	☐ Stimulants: Methamphetamine, Cocaine, other
☐ Cigarettes/Tobacco/Vape	☐ Opioids: Heroin, Methadone, Oxycodon, Fentanyl, other

Do you exercise regularly? If so, please describe what type and how often?

Surgery/Significant Injury History

Please list any past surgeries, significant injuries, or hospitalizations with date(s) included:

Significant Illness/Family History

Do you or anyone in your biological family (mother, father, siblings, grandparents, children) have a history of:

Arthritis	Asthma/COPD	Autoimmune Disease	Blood Disorder/Anemia
☐ You	☐ You	☐ You	☐ You
☐ Family	☐ Family	☐ Family	☐ Family

Cancer	Diabetes	Drug/Alcohol Abuse	Eating Disorder	Trauma/Abuse
☐ You	☐ You	☐ You	☐ You	☐ You
☐ Family	☐ Family	☐ Family	☐ Family	☐ Family

Heart Disease	Hepatitis	Hypertension	Inflammatory Bowel Disease
☐ You	☐ You	☐ You	☐ You
☐ Family	☐ Family	☐ Family	☐ Family

Kidney Disease	Mental Illness	Seizure Disorder	Stroke	Thyroid Disease
☐ You	☐ You	☐ You	☐ You	☐ You
☐ Family	☐ Family	☐ Family	☐ Family	☐ Family

General Health

Please check all symptoms that you have experienced in the past 6 months:

TEMPERATURE

☐ Chills	☐ Cold hands and feet	☐ Hot at night	☐ Hot hands, feet or chest
☐ Night sweats	☐ “cold” in the bones	☐ Hot flashes	☐ Unusual sweats

ENERGY

☐ Energy drop after eating	☐ Easily tired	☐ Unexplained weight loss
☐ Energy drop during the day	☐ Wired or ungrounded feeling	☐ Unexplained weight gain

SLEEP

☐ Difficulty falling asleep	☐ Disturbing dreams	☐ Light sleeper	☐ Not rested upon waking
☐ Waking during the night	☐ Restless sleep	☐ Heavy sleeper	☐ Vivid dreams

SKIN & HAIR

☐ Cysts/tumors	☐ Dandruff	☐ Dry hair	☐ Dry, brittle nails	☐ Dry tongue	☐ Rashes
☐ Eczema	☐ Itching skin	☐ Oily hair	☐ Dry skin	☐ Oily skin	☐ Acne

EYES

☐ Blurred vision	☐ Recent visual changes	☐ Dry eyes	☐ Floating spots
☐ Itchy eyes	☐ Poor night vision	☐ Red eyes	☐ Cataracts

HEAD

☐ Dizziness	☐ Vertigo	☐ Inability to concentrate	☐ Poor memory
☐ Concussion	☐ Headaches	☐ Migraines	☐ Nausea w/ headaches

EMOTIONS (please check those which dominate your experience)

☐ Anger	☐ Excessive joy	☐ Indecisiveness	☐ Timidness/shyness
☐ Fear	☐ Irritability	☐ Easily stressed	☐ Obsessive thinking
☐ Worry	☐ Anxiety	☐ Sadness/grief	☐ Depression

EARS/NOSE/THROAT

☐ Frequent ear infections	☐ Bleeding gums	☐ Upper respiratory issues	☐ Phlegm in the throat
☐ Recurring sore throats	☐ Tooth problems	☐ Frequent colds/flus	☐ Dry mouth
☐ Difficulty swallowing	☐ Teeth grinding	☐ Sinus infections	☐ Hay fever/allergies
☐ Frequent ear infections	☐ Ringing in ears	☐ Hearing loss	☐ Excessive earwax

CHEST/LUNGS/HEART

☐ High blood pressure	☐ Chest pain	☐ Frequent sighing	☐ Frequent cough
☐ Low blood pressure	☐ Pacemaker	☐ Shortness of breath	☐ Excessive phlegm
☐ Irregular heartbeat	☐ Heart murmur	☐ Difficulty breathing	☐ Chest tightness
☐ Palpitations	☐ Fainting	☐ Coughing blood	☐ Weak voice

MUSCULAR-SKELETAL

☐ Neck pain	☐ Muscle spasms/twitches	☐ Muscle weakness	☐ Paralysis
☐ Shoulder pain	☐ Muscle cramps	☐ Swelling of hands/feet	☐ Bruise easily
☐ Low-back pain	☐ Sore/cold/weak knees	☐ Numbness of limbs	☐ Varicose veins
☐ Mid-back pain	☐ Joint pain	☐ Pins and needles in fingers	☐ Body/limbs heavy

GENITO-URINARY

☐ Kidney stones	☐ Cloudy urine	☐ Frequent urinary tract infections	☐ Waking to urinate
☐ Frequent urination	☐ Dark urine	☐ Difficult to stop or start urinating	☐ Urgency to urinate
☐ Burning urination	☐ Blood in urine	☐ Difficulty emptying bladder	☐ Unable to hold urine

GASTRO-INTESTINAL

☐ Bad breath	☐ Foul-smelling stools	☐ Indigestion/heartburn	☐ Excessive appetite
☐ Belching	☐ Blood in stools	☐ Abdominal pain/cramps	☐ Low appetite
☐ Bloating	☐ Hernia	☐ Pain with bowel movements	☐ Nausea
☐ Loose stools	☐ Constipation	☐ Tired after bowel movements	☐ Vomiting
☐ Diarrhea	☐ Dry Stools	☐ Thirst with no desire to drink	☐ Excessive gas
☐ Hemorrhoids	☐ Rectal pain	☐ Prefer warm drinks	☐ Prefer cold drinks

Female Patients

Are you pregnant?

☐ Yes	☐ No

Number of pregnancies:

Is your period:

☐ Heavy	☐ Medium	☐ Light	☐ Painful	☐ Irregular	☐ Clotty
☐ Bright red	☐ Pale red	☐ Dark red	☐ Purple	☐ Brown	☐ Thin

Please check any symptoms that you experience:

☐ Cramping before period	☐ Excessive vaginal discharge	☐ Nausea with periods
☐ Cramping during period	☐ Digestive changes during menses	☐ Bloating during periods
☐ Cramping after period	☐ Frequent vaginal infections	☐ Water retention
☐ Ovulation cramping	☐ Headaches during menses	☐ Vulvar variscosities
☐ Breast distention/tenderness	☐ Pain/itching of genitalia	☐ Pain with intercourse
☐ Mid-cycle spotting	☐ Endometriosis	☐ Uterine fibroids
☐ Breast lumps	☐ Ovarian cysts	☐ Vaginal dryness
☐ Low libido	☐ Infertility	☐ Low libido

What type of birth control do you use, if any?

Is there anything else you would like me to know?

X_____ X_____

Please sign here to indicate that the information provided is accurate and to the best of your knowledge.

Date