

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.)
Cocial History		
Social History  Do you use any of the following substance	res?	
Coffee		annabis/Marijuana
Alcohol	St	timulants: Methamphetamine, Cocaine, other
Cigarettes/Tobacco/Vape	O	pioids: Heroin, Methadone, Oxycodon, Fentanyl, other
Do you exercise regularly? If so, please of	descri	be what type and how often?
See		
Surgery/Significant Injury Hist	tora	
Surgery/Significant Injury Hist Please list any past surgeries, significant i		es, or hospitalizations with date(s) included:
	,	

Si	g	nificant	II	lness/F	am	illy	History	V

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

You You You You You You Family  Family Family Family  Kidney Disease Mental Illness Seizure Disorder Stroke Thyroid Disease You You 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	Arthritis	Asthma/C	COPD Autoimi	nune Disease	Blood Disorde	er/Anemia	
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 Family  Kidney Disease Mental Illness Seizure Disorder Stroke Thyroid Disease  You You You You You  Family Family 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	You	You	You	You			
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FNERCV	Night sweats	"col	ld" in the bones	Hot flas	hes U	nusual sweats	
ENERCY							
LILINOI	ENERGY						
Energy drop after eating Easily tired Unexplained weight loss	Energy drop after	eating	Easily tir	ed	Une	explained weight loss	
Energy drop during the day Wired or ungrounded feeling Unexplained weight gain	Energy drop duri	ng the day	Wired or	ungrounded fee	ling Une	explained weight gain	
			-		1		
SLEEP	SLEEP						
Difficulty falling asleep Disturbing dreams Light sleeper Not rested upon waking	Difficulty falling	asleep	Disturbing dr	eams Ligh	t sleeper	Not rested upon waking	
Waking during the night Restless sleep Heavy sleeper Vivid dreams	Waking during th	e night	Restless sleep	Hear	y sleeper	Vivid dreams	

SKIN & HAIR						
Cysts/tumors	Dandruff	Dry hair	Dry, brittle	nails Dry	y tongue	Rashes
Eczema	Itching skin	Oily hair	Dry skin	Oil	y skin	Acne
EVEC						
EYES		1 1				
Blurred vision	Recent visu		Dry eyes	Floating spo	ts	
Itchy eyes	Poor night	vision	Red eyes	Cataracts		
HEAD						
Dizziness	Vertigo	Inabilit	ty to concentrate	Poor	memory	
Concussion	Headaches	Migrain	nes	Naus	ea w/ head	laches
EMOTIONS (ple			· ·	í <u> </u>		
Anger	Excessive joy		ecisiveness		ss/shyness	
Fear	Irritability	Easi	ly stressed	Obsessiv	e thinking	
Worry	Anxiety	Sadı	ness/grief	Depressi	on	
EARS/NOSE/TI	HROAT					
Frequent ear in	fections Blee	ding gums	Upper respira	tory issues	Phlegm	in the throat
Recurring sore	throats Toot	h problems	Frequent cold	ls/flus	Dry moi	uth
Difficulty swallowing Teeth grinding		n grinding	Sinus infectio	ons	Hay fev	er/allergies
Frequent ear in	fections Ring	ing in ears	Hearing loss		Excessiv	ve earwax
				1		
CHEST/LUNGS				l e		
High blood pressure Chest pain		st pain	Frequent sighing		Frequent cough	
Low blood pressure Pacemaker		emaker	Shortness of breath		Excessive phlegm	
Irregular heartbeat Heart murmur Difficulty breathing Chest tightness				ightness		
Palpitations	Fair	nting	Coughing l	blood [	Weak v	oice
MUSCULAR-S	KELETAL					
Neck pain Muscle spasms/twitches		ns/twitches	Muscle weakı	ness	Par	alysis
Shoulder pain Muscle cramps			Swelling of h	ands/feet		iise easily
Low-back pain			Numbness of			ricose veins
Mid-back pain	+=		Pins and needles in fingers Body/limbs h			
<u> </u>		I				

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 uring	Frequent urination	on Dark u	ırine	Diff	icult to stop or s	start urinating		
Burning urination Blood in urine Difficulty emptying bladder Unable to hold uring CASTRO-INTESTINAL  Bad breath Foul-smelling stools Indigestion/heartburn Excessive appetite Belching Blood in stools Abdominal pain/cramps Low appetite Belching 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:  Syour 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 Utterine fibroids  Breast lumps Ovarian cysts Vaginal dryness  Low libido Infertility Low libido	Burning urinatio						g U	Irgency to urinate
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Bad breath   Foul-smelling stools   Indigestion/heartbum   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   No   Number of pregnancies:  Syour 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/tiching of genitalia   Pain with intercourse   Mid-cycle spotting   Endometriosis   Uterine fibroids   Breast lumps   Ovarian cysts   Vaginal dryness   Low libido   Infertility   Low libido	GASTRO-INTES				icuity emptying	bladder	U	nable to hold urir
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Breast lumps Ovarian cysts Vaginal dryness  Low libido Infertility Low libido								
Low libido Infertility Low libido		J						
What type of birth control do you use, if any?	Low libido	1		-		السا		
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here anything else you would like me to know?			
	X		
use sign here to indicate that the information provided is accurate to the best of your knowledge.		Date	