wellBeing Acupuncture

1401 Tamiami Trail, Suite B, Punta Gorda, FL 33950 | 941-979-2004 | kathy@wellbeing-acupuncture.com

Patient Information

Name _____ Date _____

Address _____City _____State _____Zip _____

Telephone: (h) _____(c) _____Email_____

Gender: M _____F _____ Marital Status: S_____ M _____ D _____ W _____

Date of Birth _____/_____/_____ Age _____ Height _____ Weight _____

Emergency Contact _____ Relation _____

Emergency Contact Number: home_____ cell_____

Name of Physician*_____Phone number_____

(*No contact will be made without your permission)

Your Signature_____

Reason for Seeking Acupuncture Treatment:

_____

_____

_____

Please identify the health concerns that have brought you here:

CONDITION	PAST TREATMENT
A.	
HOW DOES THIS CONDITION AFFECT YOU?	
B.	
HOW DOES THIS CONDITION AFFECT YOU?	
C.	
HOW DOES THIS CONDITION AFFECT YOU?	

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Current Medications, Vitamins, Supplements and Dosages

Medications Dosage For what condition

_____

_____

_____

_____

Vitamins & Supplements Dosage For what condition

_____

_____

_____

Please list any foods, medications, or environmental substances to which you are hypersensitive or allergic and their reactions:

_____

_____

_____

Lifestyle:

Do you typically eat at least three meals a day? YES NO If no, how many? _____

Do you exercise? YES NO If yes, how long/how many days per week? _____ / _____

How many hours per night do you sleep? _____ Do you wake during the night? YES NO

Do you go back to sleep without problem? YES NO Do you wake up rested? YES NO

Occupation _____ How many hours do you work? _____

Do you enjoy work? YES NO What is one thing you receive from work? _____

What is one of the challenges with work? _____

Nicotine/Alcohol/Caffeine use: How often? _____

_____

On average how many cups of Water do you drink a day? _____ Tea? _____ Soda _____

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Interests: What do you enjoy doing?

_____

_____

_____

Family History

(check those applicable)	Self	Mother	Father	Siblings	Children
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Cancer					
Asthma/Allergies					
Mental Illness					
Alcoholism					

Other _____

_____

Childhood Illnesses _____

_____

Immunizations _____

_____

Hospitalizations and Surgeries

Reason Date Reason Date

_____ _____

_____ _____

_____ _____

In this section, **please circle** any symptoms/conditions you experience now, and **underline** any you have experienced in the past.

Emotional: Mood Swings Nervousness Mental Tension Depression Anxiety Stress

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

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Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Cataracts Glaucoma Glasses/Contacts Tearing/Dryness

Sinus Issues Earaches Teeth Issues Impaired Hearing Ear Ringing Headaches Migraines

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Issues

Respiratory:

Pneumonia Frequent Colds Difficulty Breathing Persistent Cough Shortness of Breath Asthma

Bronchitis Difficulty Breathing when lying down

Other Respiratory Issues_____

Cardiovascular:

Heart Disease Chest Pain Swelling of Hands or Feet High/Low Blood Pressure Irregular Heart Beat

Stroke Heart Murmur Varicose Veins Blood Clot

Other Cardiovascular Issues _____

Gastrointestinal:

Ulcer Changes in Appetite Nausea/Vomiting Excess Gas Heartburn Indigestion

Blood in Stools Hemorrhoids Abdominal Pain Gallbladder Stones Bloating Excess Belching

Constipation Diarrhea Rectal Bleeding

GenitoUrinary:

Kidney Stones Painful Urination Frequent Urination Unable to hold urine

Blood in Urine Frequent Urinary Infection Frequent Urination at Night

Musculoskeletal:

Neck/Shoulder Pain Upper Extremity Pain Lower Extremity Pain Muscle Weakness

Back Pain: Upper Mid Lower

Joint Pain: Where? _____

Skin and Hair:

Rashes Itching Eczema Recent Moles Hair Loss Changes in Hair or Skin Texture Acne

Hives Dry/Brittle Nails

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Neurological:

Paralysis Parkinson's Disease Seizures Vertigo/Dizziness Concussion Lack of Coordination

Loss of Balance

Numbness/Tingling: Where? _____

Endocrine:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats

Feeling Hot / Cold: Any specific time of day? _____

Female Reproductive:

Irregular Cycle Breast Lumps/Tenderness Heavy/Light Periods Vaginal Discharge

Menopausal Symptoms Premenstrual Issues Bleeding between Cycles Clotting

Length of Cycle _____ Number of Pregnancies _____ Number of Miscarriages _____

Last Pap Smear _____ Results _____Last Mammogram _____ Results_____

Male Reproductive: Prostate Issues Testicular Pain/Swelling Discharge Impotence

Have you been in any accidents or experience any significant trauma**?** _____

_____

Is there any other information you would like share to help support your journey in health and wellness?

_____

_____

Thank you,

Kathleen Koch
L.Ac., MAOM, Dipl.O.M