Sanibel Wellness
ACUPUNCTURE INFORMATION FORM

Name:_____ Date:_____

I. **Goals:** What would you most like to achieve through your work during your treatments here at Sanibel Wellness?

1._____
2._____
3._____
4._____

II. **Major Symptoms:** Please list in order of importance what symptoms are of concern to you. *(Most concerning to least, please include duration of symptom)*

1._____
2._____
3._____
4._____

III. **Family History:** Please check all that apply and how you are related.

Condition	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents
Heart Disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other Mental Illnesses					
Substance Abuse					
Osteoporosis					
Diabetes					
Glaucoma					

IV. **Nutrition**

1. Do you follow a special diet? [ ] Yes [ ] No, If yes, how would you describe the diet? (ie. Vegetarian, Vegan, Low Carb, etc.)

_____

2. What do you eat on a "typical" day?_____

a) Breakfast_____
b) Lunch _____
c) Dinner _____
d) Snacks _____
e) Foods you tend to crave _____
f) Foods you dislike _____

HEALTH: √ Check all that apply

GENERAL

Past	Present	Condition
[ ]	[ ]	Poor Appetite
[ ]	[ ]	Excessive Appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night Sweats
[ ]	[ ]	Sweat Easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor Coordination
[ ]	[ ]	Bleed/Bruise Easily
[ ]	[ ]	Catch Cold Easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong Thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	Present	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HEAD & NECK

Past	Present	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck Stiffness
[ ]	[ ]	Enlarged Lymph Glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Present	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased Hearing
[ ]	[ ]	Other: _____

EYES

Past	Present	Condition
[ ]	[ ]	Blurred Vision
[ ]	[ ]	Visual Changes
[ ]	[ ]	Poor Night Vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses/Contacts
[ ]	[ ]	Eye Inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	Present	Condition
[ ]	[ ]	Nose Bleeds
[ ]	[ ]	Sinus Infections
[ ]	[ ]	Hay Fever or Allergies
[ ]	[ ]	Recurring Sore Throats
[ ]	[ ]	Grinding Teeth
[ ]	[ ]	Difficulty Swallowing

MUSCULAR-SKELETAL

Past	Present	Condition
[ ]	[ ]	Stiff neck/shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back Pain
[ ]	[ ]	Muscle spasm, cramps, twitching
[ ]	[ ]	Sore, cold, or weak knees
[ ]	[ ]	Joint Pain

CARDIOVASCULAR

Past	Present	Condition
[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Low Blood Pressure
[ ]	[ ]	Blood Clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest Pain
[ ]	[ ]	Irregular Heart Beat
[ ]	[ ]	Cold hands/feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands/feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	Present	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic Obstructive
[ ]	[ ]	Pulmonary Disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing Blood
[ ]	[ ]	Production of Phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	Present	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stool/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad Breath
[ ]	[ ]	Rectal Pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or Cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall Bladder Disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other:_____

MALE

Past	Present	Condition
[ ]	[ ]	Pain/Itching Genitalia
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Impotence

MALE (continued)

Past	Present	Condition
[ ]	[ ]	Weak Urinary System
[ ]	[ ]	Other:_____

FEMALE

Past	Present	Condition
[ ]	[ ]	Frequent UTI
[ ]	[ ]	Frequent Vaginal Infections
[ ]	[ ]	Pain/Itching of Genitals
[ ]	[ ]	Genital lesions/discharge
[ ]	[ ]	Pelvic Inflammatory Disease
[ ]	[ ]	Irregular pap smear
[ ]	[ ]	Painful Menstrual Cycles
[ ]	[ ]	Premenstrual Syndrome
[ ]	[ ]	Abnormal Bleeding
[ ]	[ ]	Menopausal Syndrome
[ ]	[ ]	Breast Lumps
[ ]	[ ]	Hot Flashes
[ ]	[ ]	Other:_____

NEUROLOGICAL

Past	Present	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/ Tingling of Limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	

Other:_____

PSYCHOLOGICAL

Past	Present	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/Stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for Emotional
[ ]	[ ]	or Psychological problems
[ ]	[ ]	Other:_____

INFECTION SCREENING

Past	Present	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

GENITO-URINARY

Past	Present	Condition
[ ]	[ ]	Kidney Stones
[ ]	[ ]	Pain with urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other:_____