<u>All information provided on this form will remain confidential</u>

Have you had acupuncture before? ____

How did you learn about San Antonio Health Acupuncture? ____________________________

If you were referred by someone, may we thank them for the referrals? _____________________

Name: __________________________ Date of Birth: ________________ Age: _____

Address: ________________________ City: ____________ State: _____ Zip: ______

Home phone: ____________ Cell Phone: ____________ Email address: _______________

Employer: ______________________ Occupation: __________________________

Emergency Contact: ______________________ Relationship: ____________________

Phone: ____________ Address: ____

Please tell us about your health concerns and what brings you to seek treatment today.

In order of importance, please list your three most pressing reasons for today's visit:

1- ____

When did this begin? ______________ What treatments, medication or supplements, if any, have you taken for this?

____

What makes it better? __________________ What make it Worse? __________________

2- ____

When did this begin? ______________ What treatments, medication or supplements, if any, have you taken for this?

____

What makes it better? __________________ What make it Worse? __________________

3- ____

When did this begin? ______________ What treatments, medication or supplements, if any, have you taken for this?

____

What makes it better? __________________ What make it Worse? __________________

What is your opinion about the causes of your health concerns? ____________________________

What are your goals for your health? ____

Please intricate if you have experienced any of the following:

____ allergies
____ asthma
____ headaches
____ vision problem
____ sinus problem
____ fatigue
____ depression
____ sleep difficulty
____ mental health conditions
____ PSTD
____ pacemaker
____jaw pain / teeth grinding

____ chronic pain
____ muscle or joint pain
____ numbness / tingling
____ sprains / strains
____ scoliosis
____ arthritis
____ tendonitis
____ IBS
____ constipation
____ diarrhea
____ heart burn / acid reflux
____ weight changes

____ hepatitis
____ bleeding disorders
____ varicose veins
____ blood clots
____ high / low blood pressure
____ diabetes
____ cancer / tumor
____ infectious disease
____ STD's
____ skin problem
____ kidney stone
____ hair loss

Other conditions: ____

Please indicate the following:

Caffeine What drink(s)? ______________________________ Frequency_________ per ________________

Smoke: Current1y? _______Past? ____ When did you quit? ______How long? __________ Cigarettes per day_____________

Alcohol Type? _____________________Drinks per week ____________Recreational drug use? ____________________

Do you eat a special diet? ____

How much water do you drink pet day? ____

Exercise activities: ____

WOMEN:

____ PMS
____ ovarian cysts
____ very heavy periods

____ painful periods
____ breast lumps
____ clotting with periods

____ uterine fibroids
____ irregular periods

Are you pregnant? _______ Due date? ______________________ Are you trying to become pregnant? _______________

Age you began menstruation: _______________Have you reached menopause/ When? __________________________

Number of pregnancies: _______ Number of births: _________ Birth control method: _______________________

Do you do breast self-exams? ______________________ Do you get annual Pap smears? ____________________

MEN:

Prostate problem? ___________________ Erectile dysfunction? ____________________ Infertility? _________________

List all medications / herbs / supplements you are currently taking:

Medication / herb / supplement	Reason	Prescribing Practitioner

List previous major injuries / surgeries / illnesses;

Surgery / Injury / Illness:	Date

What other treatments are you receiving and by whom (MD, DO, Physical therapy, Chiropractic, Naturopathic):

____

____

What are your main activities at work? On the phone _________ Sitting ________ Computer _________ Driving car __________

Walking __________ Other ____

What do you do to relieve stress? ____

If you were to list one thing you need from our office or your practitioner today, what would that be?

____

____

____ ____

Signature: Date:

____

Print Name