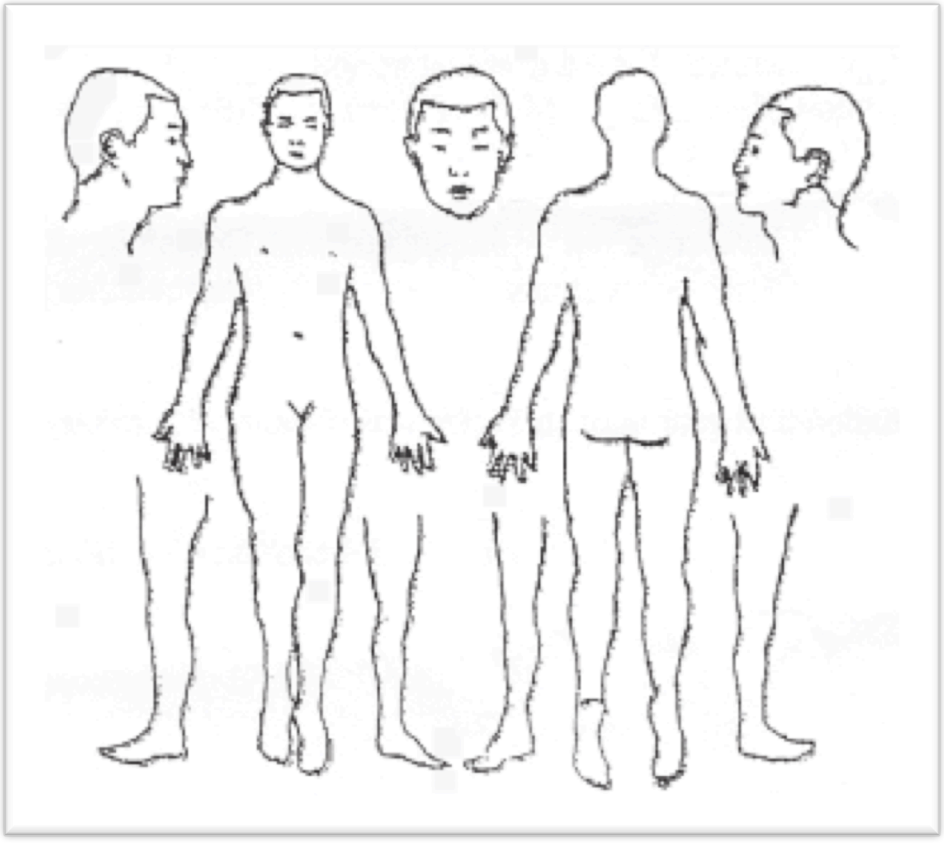
Sanctuary Community Acupuncture
1112 South Saint Mary's Street
San Antonio, Texas 78210
www.AcupunctureForAllSA.com
(210) 912-4766

PATIENT INFORMATION

Today's Date _____ / _____ / _____
Name: _____ Age: _____ D.O.B. ___ / ___ / ___
Address: _____ City:_____
State: _____ Zip: _____
Cell Phone: (_____)_____ Other phone: (_____)_____
E-Mail _____
How did you hear about our office?_____
Is this your first time receiving acupuncture?_____
Emergency Contact: Name_____ Phone_____
What are your main concerns that you would like help with?



After you have printed the document,

please mark areas where you are experiencing pain or discomfort.

Check all that apply:

- ☐ epilepsy/seizures
- ☐ Hepatitis A/B/C
- ☐ HIV+
- ☐ bleeding disorder
- ☐ stroke
- ☐ pacemaker
- ☐ fainting
- ☐ diabetes
- ☐ mental illness
- ☐ addiction
- ☐ glaucoma
- ☐ hypertension
- ☐ autoimmune disease
- ☐ thyroid disorder
- ☐ cancer

List any medications and/or nutritional supplements that you are taking.

List any surgeries or hospitalizations with date:

LIFESTYLE:	**DIGESTION**:
☐Exercise regularly ☐Eat much fast food ☐Eat much meat ☐Eat much sweets / carbs ☐Vegetarian / vegan ☐Drink alcohol daily ☐Drink sodas daily ☐Smoke cigarettes ☐Use drugs	☐Tired after meals ☐Shaky between meals□ ☐Indigestion/ reflux/ heartburn ☐Nausea / vomiting Gas /bloating ☐Windy gas ☐Odorous gas ☐Stomach ache / abdominal pain ☐Constipation ☐Diarrhea/ loose stools ☐ Light colored stools ☐Gallstones ☐Adverse reactions to specific foods

HEAD/ FACE: □ Headaches / migraines □ TMJ / jaw pain	**GENITO-URINARY:** □ Frequent urination □ Frequent urinary tract infections □ Kidney stones
TEMPERATURE / PERSPIRATION: □ Hot / Cold body sensation overall □ Aversion to heat or cold □ Cold hands / feet □ Hot flashes/ night sweats □ Spontaneous sweating	**IMMUNE / RESPIRATORY**: □ Frequent colds / sinus infections □ Chronic/ seasonal allergies □ Environmental sensitivity □ Cough □ Asthma / wheezing □ Ear ache □ Dizziness
DERMATOLOGICAL: □ Rash / itching / hives □ Acne / boils □ Hair falling out □ Weak / brittle nails □ Slow wound healing	**SLEEP:** □ Good □ Trouble Falling Asleep □ Trouble Staying Asleep □ Insomnia
EMOTIONAL / PSYCHOLOGICAL: □ Anxiety □ Depression □ Worry □ Much fears or terrors □ History of abuse	**FEMALE ONLY:** □ May be pregnant □ Irregular cycle □ Painful periods □ Heavy / scanty periods □ Osteopenia/Osteoporosis