

Welcome to Triangle Acupuncture Clinic. To help me provide you with the best possible care, please fill out this form carefully. All the information will be kept confidential in your patient file. If you have any questions, please ask. Thank you for your time.

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____ email: _____

In Case of Emergency, contact: _____ phone: _____

Birth Date: _____ Marital Status: _____ Occupation: _____

Age: _____ Height: _____ Weight: _____ Sex: _____ Social Security #: _____

Primary Physician: _____ Date of last visit: _____

Other Physicians you see regularly and for what conditions:

Past & Family Medical History

Please list any major illnesses and injuries and the date of onset:

List any operations not listed above:

Are you now, or is there any possibility that you may be pregnant? _____

Do you smoke or chew tobacco? _____ How much, how often? _____

Do you consume caffeine? _____ How much, how often? _____

Do you consume alcohol? _____ How much, how often? _____

List any and all medications you are taking, including over-the-counter medications, oral contraceptives, vitamins and supplements. Include dosages if possible: _____

List drug allergies: _____

Please list any major stresses in your life:

Check where applicable:	Self	Mother	Father	Sibling	Spouse	Child
Allergies						
Anemia						
Cancer						
Diabetes						
Drug use						
High blood pressure						
Stroke						
Heart disease						
Tuberculosis						
Depression						
Mental illness						
Other						
Age at death						

Please describe the main health concerns you would like to address:

Please describe what features of your face you would like to address:

What kinds of treatments, drugs or therapies have you tried for these health or cosmetic concerns?

What to Expect, Precautions and Policies:

Certain adverse effects may result from treatment. These could include but are not limited to some local bruising, minor bleeding, fainting, temporary pain or discomfort and the possible temporary aggravation of symptoms existing prior to acupuncture treatment. You may experience a feeling of light-headedness after treatment. If this is the case, please sit for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed. If during the treatment, you experience a headache, neck tenderness or any other discomfort, please notify the acupuncturist. This is a medical treatment, but it should also be therapeutic and relaxing.

Because of the possibility of drug interaction with herbal formulas, we require our patients to inform the practitioner of any medications they may be taking, including any dietary supplements and herbs. **Acupuncture points and herbal formulas may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy. Facial Rejuvenation is contraindicated if you are pregnant, HIV positive or have AIDS, cancer, hepatitis, high blood pressure, are prone to frequent migraine headaches or seizures, have a cold or flu or a current herpes outbreak. You must notify your acupuncturist if you have any of these conditions.**

The confidentiality of the patient is maintained at all times by the practitioner. It should be noted that acupuncture treatments are performed with sterile, disposable needles that are thrown away after one use.

All fees for services are due at the time of treatment. If you need to cancel an appointment, please give a minimum of 24 hours notice. You are entitled to one missed appointment for emergencies; after that, you will be charged the full amount for any appointments not cancelled with 24 hours notice.

I understand the above statements and will comply with the stated needs and requests of the clinical personnel in order to retain this unique health care service in the state of North Carolina

Patient Signature: _____ Date: _____