



Triangle Acupuncture Clinic, LLC  
919-933-4480  
www.triangleacupunctureclinic.com

Welcome to Triangle Acupuncture Clinic. To help us 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 us. Thank you for your time.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Email: \_\_\_\_\_  
In Case of Emergency, Contact: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ How did you hear about us?: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Social Security # \_\_\_\_\_ Occupation: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_  
Primary Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Other Physicians You See Regularly and For What Conditions: \_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION:** If you have health insurance, you may be eligible for a 20% discount on acupuncture services at our clinic. You may request a receipt which you can send in to your insurance company for potential reimbursement. We do not bill insurance at this time. Payment is due at the time of service.

Primary Insurance: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (    ) \_\_\_\_\_ Employer: \_\_\_\_\_  
Policy Holders Name: \_\_\_\_\_ ID Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PAST AND FAMILY MEDICAL HISTORY:**

Please list any major illnesses and the date of onset: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Females: \_\_\_\_\_ Date of last PAP: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

List any operations not listed above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any major sources of stress in your life:

**Family History: Please check all that apply**

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
Allergies							
Anemia							
Cancer							
Diabetes							
Drug Use							
High Blood Pressure							
Stroke							
Heart Disease							
Tuberculosis							
Depression							
Mental Illness							
Hepatitis							
HIV/AIDS							
Other							
Age at Death							

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?:

Mark an 'X' in the box next to any of the following that you are now taking:

aspirin ☐

diet pills ☐

cold tablets ☐

oral contraceptives ☐

antacids ☐

sleeping pill ☐

tranquilizers ☐

blood pressure pills ☐

ibuprofen ☐

fiber ☐

List all vitamins & supplements:

laxatives ☐

acetaminophen ☐

Please list all medications you are taking and dosages:

List Drug Allergies:

**CURRENT HEALTH:**

Please describe the main problem you would like to address:

When did the first symptoms begin?

Have you been given a diagnosis by your primary physician? If so, what?

What kinds of treatments, drugs or therapies have you tried? With what success?

Please list your goals for healing with regards to this condition:

#### **FEES AND CANCELLATION POLICY**

All fees for medical services are due at the time of each treatment. Please refer to the "Insurance Information" section on page 1 for information on insurance billing at this office.

**We do not over-book our schedule, your appointment time is saved especially for you. If you need to cancel an appointment, please give us a minimum of 24 hours notice. You will be charged the full cost of your treatment if you fail to cancel without 24 hours notice. Of course, emergencies will be taken into consideration.**

Because of the possibility of drug interaction with herbal formulas, we require our patients to inform the practitioner of all medications they may be taking, including any dietary supplements and herbs. **Herbal formulas and acupuncture points may have effects on pregnancy. Patients must inform the practitioner of any possibility of pregnancy.**

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

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: \_\_\_\_\_