



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 questions please ask us. Thank you for your time.

CONTACT INFORMATION

Name: _____ Today's Date: _____

Street Address: _____ City, State: _____ Zip: _____

Parent/Guardian Name: _____

Primary Phone: () _____ Please indicate: home work cell (circle one)

Secondary Phone: () _____ Please indicate: home work cell (circle one)

Circle the Best Number to Reach You: primary secondary

Email Address: _____

In Case of Emergency, Contact: _____ Phone: () _____ circle: h w c

Birth Date: _____ How did you hear about us? _____

Age: _____ Height: _____ Weight: _____ Sex: _____

Primary Physician's Name: _____ Date of last visit: _____

Other Health Care Providers Your Child Sees Regularly and For What Conditions:

CURRENT HEALTH

Please describe your child's main health concern you would like to address:

When did the first symptoms begin?

What in your child's past do you think may have contributed to this problem?

What diagnosis has your child been given by his/her health care provider?

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

Please list your/your child's goals for healing with regards to this condition:

Please list any major sources of stress in your child's life:

Does your child consume caffeine? How much and how often?

Does your child consume sugar? How much and how often?

Briefly describe your child's diet, including any special diets:

What vaccinations has your child received and at what age?

Please list all vitamins and supplements your child is taking:

Please list all prescription and over-the-counter medications your child is taking, dosages for each and the reason for taking them: (use the back of form if more room is needed):

List any drug allergies:

Please list strengths, goals or obstacles your child may have in the following areas:

Physical: _____

 Emotional: _____

 Mental: _____

 Hobbies/Interests: _____

PAST AND FAMILY MEDICAL HISTORY

Please list any major illnesses and operations, and the date of onset of each:

Please check all that apply:

	Your Child	Mother	Father	Sibling	Sibling	Sibling
Allergies						
Anemia						
Cancer						
Diabetes						
High Blood Pressure						
Stroke						
Heart Disease						
Depression						
Mental Illness						
Hepatitis						
HIV/AIDS						
Autoimmune Disease						
Infectious Disease						
MRSA/Staff Infection						
Other						
Age at Death						

Please continue to the following forms: HIPAA, Office Policy, and Arbitration/Informed Consent (front and back)