



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: _____

Primary Phone: () _____ circle: home work cell

Secondary Phone: () _____ circle: home work cell

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? _____

Marital/Relationship Status: _____ Occupation: _____

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

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

OB/GYN and other Health Care Providers you see regularly: _____

CURRENT HEALTH

Please describe the main problem you would like to address: _____

When did the first symptoms begin? _____

What diagnosis have you been given by your health care provider? _____

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

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

Please list any major sources of stress in your life: _____

Do you smoke/chew tobacco? How much and how often?

Do you consume caffeine? How much and how often?

Do you consume alcohol? How much and how often?

Do you use recreational drugs? How much and how often?

Please list all vitamins and supplements you are taking:

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

List any drug allergies:

MEDICAL HISTORY

Date of last Period: Date of last PAP: Date of last Mammogram:

Date of last appointment with OB/GYN: Estimated Due Date:

No. of Pregnancies: No. of Children and Ages: No. of Abortions:

No. of Miscarriages: Are you carrying Multiples?

List any other symptoms or health concerns you've experienced related to your pregnancy:

Describe your exercise routine:

Describe your diet and any digestive issues:

Describe any emotional or stress related issues:

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

FAMILY MEDICAL HISTORY

Please check all that apply:

	Self	Mother	Father	Sibling	Sibling	Spouse	Child
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

Arbitration/Informed Consent (front and back)