



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:
Age:	Height:	Weight:	Sex:
E-mail:		Home Phone: ()	
Parent/Gaurdian Name:		Work Phone: ()	
In Case of Emergency Contact:			
Birth Date:		How did you hear about us:	
Primary Physician's Name:		Date of Last Visit:	
OB/GYN and other physician's you see regularly:			

INSURANCE INFORMATION: You may request a reciept 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 #:

HEALTH CONCERNS

Please Describe the Main Health Concern you would Like to Address:

When did the symptoms first begin?

Have you been given a diagnosis by your primary physician? Explain.

What other treatments have you tried? With what success?

Patient Name:

Date:

HEALTH HISTORY

Date of Last Period:

Date of last PAP:

Date of last mammogram:

Date of Last appointment with OB/GYN

Findings:

Due Date:

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

Describe Exercise Routine:

Describe Eating Habits, Digestion Issues:

Describe any emotional or stress related issues:

Do you consume caffeine?:

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 ☐

laxatives ☐

acetaminophen ☐

List all other medications you take:

List all vitamins and supplements you take:

PAST MEDICAL HISTORY

Please list any major illnesses and the date of onset:

List any operations not listed above:

Check any that apply:

	Self	Mother	Father	sibling	sibling	spouse	child	other
Allergies								
Anemia								
Cancer								
Diabetes								
Drug Use								
Hypertension								
Stroke								
Heart Disease								
Tuberculosis								
Depression								
Mental Illness								
Other								
Age at Death								

If this is not your first pregnancy, please tell us about any complications or health issues that were present with previous pregnancies:

Are there any other thoughts or information related to your physical or emotional health that you would like to share?