

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:		Referred by:	
Marital Status:		Social Security #	Occupation:
Age:	Height:	Weight:	Sex:
Primary Physician's Name:			Date of last visit:
Ob/Gyn Name:			Date of last visit:
Reproductive Endocrinologist's Name:			Date of last visit:
Other Physician's You See Regularly and For What Conditions:			

**INSURANCE INFORMATION:** (not all companies cover acupuncture)

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

**PAST AND FAMILY MEDICAL HISTORY:**

Please list any major illnesses or surgeries and the date:

\_\_\_\_\_

\_\_\_\_\_

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?

How many glasses of water do you drink per day? \_\_\_\_\_

What other beverages do you consume daily: milk    juice    soda    other\_\_\_\_\_

Briefly describe your diet:

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 vitamins & supplements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are taking and amounts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Drug Allergies: \_\_\_\_\_  
\_\_\_\_\_

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

**Fertility History:** Please fill in, check or circle answers and feel free to write in margins if more room is needed

Age period began: \_\_\_\_\_

How many days do you normally bleed? \_\_\_\_\_

How heavy is the bleeding?                      Light                      Medium                      Heavy

What color is the blood?                      Light red                      Red                      Dark Red                      Purple                      Brown                      Black

What is the consistency of the blood?                      watery                      thick                      clots                      dry                      phlegmy

Do you suffer from painful periods? \_\_\_\_\_

When and how many days do you have pain? \_\_\_\_\_

	Yes	No
Premenstrual Moodiness		
Premenstrual Low Back Pain		
Premenstrual Acne or Breakouts		
Premenstrual Breast Tenderness		
Loose Bowels Premenstrually or During Period		
Premenstrual Water Retention or Bloating		
Bleed or Spot Between Periods		
Do you douche		
Do you use vaginal lubricants during sex		

Does your menstrual cycle follow a regular pattern? \_\_\_\_\_

How many days from the start of one period to the start of another? \_\_\_\_\_

Do you ovulate on your own? \_\_\_\_\_

On what day of your cycle? \_\_\_\_\_

Have your cycles changed since they began or at any point in time recently? How? \_\_\_\_\_

**Date of Last Menstrual Period:** \_\_\_\_\_

How many pregnancies have you had? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

How many abortions have you had? \_\_\_\_\_ How many miscarriages have you had? \_\_\_\_\_

How many times has a D & C been performed? \_\_\_\_\_

**Please Circle and indicate the date if you have had any of the following:**

abnormal pap smear

chronic vaginal discharge

venereal disease

pelvic inflammatory disease

chlamydia

uterine fibroids or polyps

yeast infection

genital sores

endometriosis

pelvic abnormalities

pelvic adhesions

cervical biopsy/operation

hemorrhage

other: \_\_\_\_\_

Have you taken any medications for any other gynecological conditions? \_\_\_\_\_

Have you ever taken oral contraceptives? When and how long? \_\_\_\_\_

Have you ever had an IUD or taken DepoProvera? When and how long? \_\_\_\_\_

How long have you been trying to conceive? \_\_\_\_\_

Cause of Infertility (Doctor's Diagnosis): \_\_\_\_\_

Are your fallopian tubes open? \_\_\_\_\_ Have you had abdominal surgery? \_\_\_\_\_

What is your day 3 FSH? \_\_\_\_\_ Prolactin level? \_\_\_\_\_

Have your estrogen or progesterone levels been found to be low? \_\_\_\_\_

Have you taken Clomid? \_\_\_\_\_ How many months? \_\_\_\_\_ Side Effects: \_\_\_\_\_

Describe in chronological order any other fertility treatments; injectables, IUI, IVF, FET:

Date (month/year): \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Is your partner supportive of your wish to conceive? \_\_\_\_\_

Male partners: Has he had a fertility workup? Results? \_\_\_\_\_

How is your sexual energy?            Low            Normal            High

How is your relationship with your partner now?            Not Good            Stressed            Good            Awesome

Do you have a support system of friends and family? \_\_\_\_\_

Describe your stress level and any predominant emotions you are experiencing \_\_\_\_\_

What do you currently do to promote relaxation and combat stress? \_\_\_\_\_

Any other thoughts or information related to your physical or emotional health that you would like to share? \_\_\_\_\_

All fees for medical services are due at the time of each treatment.

Triangle Acupuncture Clinic accepts a discounted rate for some insurances.

I authorize the release of any medical or other information necessary for insurance claim processing.

**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.**

Sometimes after an acupuncture treatment you may feel a little bit light headed. 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. 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.

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. **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 thrown away 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: \_\_\_\_\_