

104 S. Estes Dr Suite 104 Chapel Hill, NC 27514 2601 Lake Dr. Suite 103 Raleigh, NC 27607

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:		ip:				
Primary Phone: ()		Please indicate: home worl			(circle one)			
Secondary Phone: ()		Please indicate:	home wor	k cell	(circle one)			
Circle the Best Number to Reach	You: primary second	lary						
Email Address:								
In Case of Emergency, Contact:		Phon	e:()		circle: h	w c		
How did you hear about us?								
We like to thank those that refer	to us. Name of person	who referred you:						
Marital/Relationship Status:		Occupation:						
Birth Date + Age:	Height:	Weight:	Sex:					
Primary Physician's Name:		Date of last visit:						
Other Health Care Providers You	ı See Regularly and For	What Conditions:						
CURRENT HEALTH								
Please describe the main probler	n you would like to addı	ress:						
When did the first symptoms be	gin?							
What in your past do you think n		this problem?						
what in your past do you think i	nay have contributed to	tilis problem;						
What diagnosis have you been gi	yon by your boolth coro	provider?						
villat diagnosis nave you been gi	ven by your nearm care	provider:						

please continue to next page

What kinds of treatments, drugs or therapies have you tried? With what success?						
Please list your goals for healing with r	regards to this condition:					
Please list any major sources of stress i	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 supplement	ts you are taking:					
Please list all prescription and over-the taking them: (use the back of form if m	e-counter medications you are taking, dosages for each and why you are nore room is needed):					
List any drug allergies:						
, , ,						
PAST MEDICAL HISTORY						
Please list any major illnesses and open	rations, and their date of onset:					
	·					
For Females: Date of last PAP:	Date of last mammogram:					
please continue to next page						

FAMILY MEDICAL HISTORY

Please check all that apply:

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	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							

${\it Please continue\ to\ the\ following\ forms:}$

HIPAA

Office Policy

 $Arbitration/Informed\ Consent\ (front\ and\ back)\ *This\ form\ is\ completed\ in\ the\ office.$