triangle ACUPUNCTURE clinic, LLC

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: Zip:

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

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:

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:

please continue to next page

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 continue to next page

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) *This form is completed in the office.*