

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: \_\_\_\_\_

Social Security # \_\_\_\_\_ Home Phone: (    ) \_\_\_\_\_

Parent/Gaurdian Name: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

In Case of Emergency Contact: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Other physician's your child sees regularly and for what conditions: \_\_\_\_\_

#### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (    ) \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ ID Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary 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 and how long has this been going on?

Have you been given a diagnosis by your primary physician?

What other treatments have you tried? With what success?

Patient Name:

Date:

HEALTH HISTORY

Please list any major illnesses and the date of onset:

List any operations not listed above:

	Child	Mother	Father	sibling	sibling	paternal family/maternal family
Allergies						
Anemia						
Cancer						
Diabetes						
Drug Use						
Hypertension						
Stroke						
Heart Disease						
Tuberculosis						
Depression						
Mental Illness						
Other						
Age at Death						

Does your child consume caffeine?

How much?How often?

What vaccinations has your child received and on what date:

Mark an X in the box next to any of the following that your child is now taking:

aspirin<sup>1</sup>

diet pills<sup>1</sup>

cold tablets<sup>1</sup>

fiber<sup>1</sup>

ibuprofen<sup>1</sup>

sleeping pills<sup>1</sup>

tranquilizers<sup>1</sup>

laxatives<sup>1</sup>

acetaminophen<sup>1</sup>

vitamins:

supplements:

Please list all medications your child is taking and amounts:

List Drug Allergies:

Patient Name:

Date:

Please list strengths, goals or obstacles your child may have in the following areas:

Physical:

Emotional:

Mental:

Hobbies/Interests:

All fees for medical services are due at the time of each treatment. If your insurance covers acupuncture we will bill them for you. We also accept a discounted rate for some insurances. I authorize the release of any medical or other information necessary for insurance claim processing.

If you need to cancel an appointment, please give us a minimum of 24 hours notice. There will be a \$25 cancellation fee for shorter notice or a no-show, and chance of being on a same day appointment basis.

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: