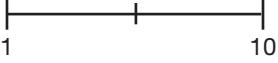
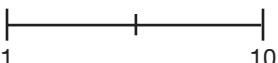
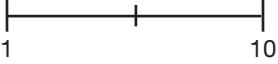


NEW PATIENT INTAKE FORM

Name:		Gender:	Today's Date:
Legal Name if different from above [optional]:		Date of Birth:	
Address:			
Phone:		Email:	
Height:		Weight:	
Employer:		Occupation:	
Physician Name & Phone:			
Emergency Contact Name & Phone:			
Current Relationship Status [single, married, partnered, etc]:			
Is this your first time having acupuncture?		How did you hear of Five Pins Project?	

MAIN COMPLAINTS

Please list your top three complaints/concerns in order of importance to you.	Mark an X on the scale to indicate the severity of the condition.	When did this start?	Indicate by circling whether each of the following makes it Better, Worse, or No Change			
			Heat	Cold	Damp	Exercise
#1:			Better	Better	Better	Better
			Worse	Worse	Worse	Worse
			No Change	No Change	No Change	No Change
#2:			Better	Better	Better	Better
			Worse	Worse	Worse	Worse
			No Change	No Change	No Change	No Change
#3:			Better	Better	Better	Better
			Worse	Worse	Worse	Worse
			No Change	No Change	No Change	No Change

HEALTH HISTORY

Check the YOU box if you have or had the condition and note the year it began. Check the FAMILY box if there is a family history.

CONDITION	YOU	YEAR	FAMILY
Cancer (specify)	<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>		<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>		<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>		<input type="checkbox"/>
Stroke	<input type="checkbox"/>		<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>		<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>		<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>		<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>		<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>		<input type="checkbox"/>
STD (specify)	<input type="checkbox"/>		<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>		<input type="checkbox"/>
Substance dependency	<input type="checkbox"/>		<input type="checkbox"/>
Allergies (specify)	<input type="checkbox"/>		<input type="checkbox"/>
Psychological (specify)	<input type="checkbox"/>		<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>		<input type="checkbox"/>
Anemia	<input type="checkbox"/>		<input type="checkbox"/>
History of trauma	<input type="checkbox"/>		<input type="checkbox"/>

INJURIES & SURGERIES (including dental)

Please list what happened to what body area and when it occurred.

MEDICATIONS

Please list any medications, herbs or supplements that you take regularly.

DIET & EXERCISE

Do you have a special diet now or have you had one in the past?

Do you exercise regularly? If so, what and how often?

Do you use or have you used any of the following? How often?

	Amount per week	If quit, how long ago?
Coffee / Tea	<hr/>	<hr/>
Soda	<hr/>	<hr/>
Tobacco	<hr/>	<hr/>
Alcohol	<hr/>	<hr/>
Other drugs	<hr/>	<hr/>

NEW PATIENT INTAKE FORM

HEALTH QUESTIONNAIRE

Mark an X on the scales and check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections.

TEMPERATURE

How warm or cold you feel relative to other people.
Do you usually need to wear more layers or fewer?

COLD |————| HOT

<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Unusual sweats (specify when, where on body)
<input type="checkbox"/> Chills	_____
<input type="checkbox"/> Cold "in the bones"	_____
<input type="checkbox"/> Numbness	_____
<input type="checkbox"/> Thirst, no desire to drink	<input type="checkbox"/> Hot hands, feet, or chest
<input type="checkbox"/> Absence of thirst	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Hot in afternoon
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Hot at night

MOISTURE

Overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |————| OILY

<input type="checkbox"/> Dry skin	<input type="checkbox"/> Edema / swelling (where? _____)
<input type="checkbox"/> Dry hair	<input type="checkbox"/> Rashes (where? _____)
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Itching (where? _____)
<input type="checkbox"/> Dry, brittle nails	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Oily skin
<input type="checkbox"/> Dry lips	<input type="checkbox"/> Oily hair
<input type="checkbox"/> Dry throat	<input type="checkbox"/> Pimples
<input type="checkbox"/> Dry nose	<input type="checkbox"/> Weight gain or loss
<input type="checkbox"/> Nosebleeds	

DIGESTION

DIARRHEA |————| CONSTIPATION

BM: How often? _____ x every _____ days

Stools keep shape? Yes No

<input type="checkbox"/> Alternating diarrhea & constipation / IBS	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hernia
<input type="checkbox"/> Gas	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bloating	<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Belching	<input type="checkbox"/> Dry stools
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Difficult to pass
<input type="checkbox"/> Nausea	<input type="checkbox"/> Tired after BM
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Pain with BM
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Foul-smelling stools

ENERGY

LOW |————| HIGH

<input type="checkbox"/> Sudden energy drop (time of day? _____)	<input type="checkbox"/> Blood pressure high / low
<input type="checkbox"/> Energy drop after eating	<input type="checkbox"/> Bleed / bruise easily
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Difficulty concentrating
<input type="checkbox"/> Dependence on caffeine/stimulants	<input type="checkbox"/> Poor memory
<input type="checkbox"/> Wired or ungrounded feeling	<input type="checkbox"/> Dizziness / lightheadedness
<input type="checkbox"/> Body or limbs feel heavy	<input type="checkbox"/> Headaches: _____ x per week
<input type="checkbox"/> Body or limbs feel weak	
<input type="checkbox"/> Shortness of breath	

EMOTIONS

What emotions dominate your experience?

<input type="checkbox"/> Anger	<input type="checkbox"/> Obsessive Thinking	<input type="checkbox"/> Joy
<input type="checkbox"/> Irritability	<input type="checkbox"/> Sadness	<input type="checkbox"/> Fear
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Grief	<input type="checkbox"/> Timidness / Shyness
<input type="checkbox"/> Worry	<input type="checkbox"/> Depression	<input type="checkbox"/> Indecisiveness

SLEEP

of hours per night: _____

<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Disturbing dreams
<input type="checkbox"/> Wake _____ x per night @ _____ am / pm	<input type="checkbox"/> Restless sleep
<input type="checkbox"/> Wake to urinate: how often?	<input type="checkbox"/> Not rested upon waking

HEALTH QUESTIONNAIRE CONTINUES ON NEXT PAGE

NEW PATIENT INTAKE FORM

HEALTH QUESTIONNAIRE (continued)

Mark an X on the scales and check any boxes of symptoms or conditions you have had **in the past month**, in any applicable sections.

EYES, EARS, NOSE, THROAT

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Excessive earwax
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Phlegm (color? _____)	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Spots in vision		<input type="checkbox"/> Cough

URINARY

<input type="checkbox"/> Decrease in flow	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Pain on urination
<input type="checkbox"/> Dribbling	<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Burning sensation on urination
<input type="checkbox"/> Difficulty starting or stopping	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Cloudy urine
		<input type="checkbox"/> Blood in urine

REPRODUCTIVE

Are you sexually active? Yes No

Any recent changes in sex drive? Yes No

Sores on genitals
 Genital discharge
 Genital pain
 Pain with orgasm
 Pain on penetration

Penile & Prostate (If applicable):
 Erectile dysfunction
 Premature ejaculation
 Jock itch Vasectomy
 Prostate disease

MENSES & PREGNANCY

if applicable

Age at first menses: _____

Average length of full cycle: _____ days (i.e. 28)

Average length of menses: _____ days (i.e. 3-4)

Last menses start date: _____

of pregnancies: _____ # of births: _____ premature: _____

of abortions or miscarriages: _____

Do you take hormonal birth control pills? _____

Periods

Heavy
 Light
 Painful
 Irregular

Cramps

before bleeding
 first day
 during period

Changes in body/psyche prior to menstruation
 Clots Fatigue

Breast tenderness
 Mood changes
 Digestive changes
 Mid-cycle spotting

MENOPAUSE

If applicable

Age at last menses: _____ Vaginal dryness
Year changes began: _____ Loss of sex drive
 Hot flashes: Night sweats:
_____ x per day _____ x per week

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Right to Obtain a Copy of the Notice:

You have the right to ask for and get a paper copy of the notice of privacy practices, and any revisions we make to the notice at any time.

➤ As indicated by my signature below I hereby acknowledge receipt and understanding of the Notice of Privacy Practices.

Print Patient's Name: _____

Signature of Patient or Person Authorized to Consent: _____

Date: _____

INFORMED CONSENT

Voluntary Consent

I hereby voluntarily request and consent to be treated, or give permission for my child/ward to be treated, with acupuncture; electro-acupuncture; acupressure and other techniques based on Traditional Asian Medicine. I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques; electrical stimulation; or touch/palpation. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions

I understand that these treatments may result in certain side effects, including local bruising; slight bleeding; fainting; temporary pain or discomfort; and temporary aggravation of symptoms existing prior to treatment. Unusual and rare risks of acupuncture include nerve damage, organ puncture, and infection. I have read the information on this page and understand the possible risk involved.

Medical Referral

I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician. I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician. If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments. I certify that I have informed The practitioner of all known physical, mental, and medical conditions and medications, including possible pregnancy, and that I will notify The practitioner of any changes.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards. Needles are disposed of as medical waste immediately after use. I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure. I have read this form carefully. I have felt free to ask any questions, and it has been satisfactorily explained to me.

Payment and Cancellation Policies

The initial visit is \$210. Follow up sessions are \$160. Full payment is expected at the time services are rendered. We accept Venmo, credit cards, HSA/FSA cards and cash.

If you must cancel or reschedule your appointment, we require 24 hours notice to avoid a cancellation fee of \$160. Please note that any cancellation fee is the responsibility of the patient, as we cannot bill your insurance for missed appointments.

If you are unable to pay full price for treatments, please let us know. There is a sliding scale option for people who need it. We offer a sliding scale so that patients are empowered to decide what they are able to pay, and so that Five Pins Project can remain a healthy and viable business.

➤ **I have read and understand the above, and I agree to be treated.**

Name: _____

Signature: _____ Date: _____