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:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse No Change
#2:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse No Change
#3:	1 — 10		Better Worse No Change	Better Worse No Change	Better Worse No Change	Better Worse 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)	☐		☐
Diabetes	☐		☐
Hepatitis	☐		☐
High blood pressure	☐		☐
Heart Disease	☐		☐
Stroke	☐		☐
Seizure disorder	☐		☐
Thyroid disease	☐		☐
Asthma	☐		☐
Pacemaker	☐		☐
Eating disorder	☐		☐
Osteoporosis	☐		☐
STD (specify)	☐		☐
Rheumatic fever	☐		☐
Substance dependency	☐		☐
Allergies (specify)	☐		☐
Psychological (specify)	☐		☐
Kidney disease	☐		☐
Anemia	☐		☐
History of trauma	☐		☐

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	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Other drugs	_____	_____

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

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

MOISTURE

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

DRY ——— OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry, brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose
- ☐ Nosebleeds
- ☐ Edema / swelling (where? _____)
- ☐ Rashes (where? _____)
- ☐ Itching (where? _____)
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain or loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____ x every _____ days
Stools keep shape? ☐ Yes ☐ No

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

ENERGY

LOW ——— HIGH

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

EMOTIONS

What emotions dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive Thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timidness / Shyness
- ☐ Indecisiveness

SLEEP

of hours per night: _____

- ☐ Difficulty falling asleep
- ☐ Wake ____ x per night @ _____ am / pm
- ☐ Wake to urinate: how often?
  _____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ 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

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in vision
- ☐ Sinus congestion
- ☐ Phlegm (color? _____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excessive earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting or stopping
- ☐ Incontinence
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation on urination
- ☐ Cloudy urine
- ☐ 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

MENOPAUSE

If applicable

Age at last menses: _____

Year changes began: _____

- ☐ Hot flashes: _____ x per day
- ☐ Vaginal dryness
- ☐ Loss of sex drive
- ☐ Night sweats: _____ x per week

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

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:** _____