



Points of Origin, PLLC  
18810 NE 18<sup>th</sup> Street  
Vancouver, WA 98684

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Phone: (360) 449-4500

**NEW PATIENT INTAKE FORM**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(please feel free to attach any additional information)*

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Marital Status \_\_\_\_\_ Age \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

M  F Ht \_\_\_\_\_ Wt \_\_\_\_\_ Occupation \_\_\_\_\_ Retired Y / N

Home Phone (\_\_\_\_) \_\_\_\_\_ Work / Cell Phone (\_\_\_\_) \_\_\_\_\_

Permission to add you to our valued subscriber's list – free monthly newsletter & specials: Y / N

Email address \_\_\_\_\_

Emergency Contact Person and Phone # \_\_\_\_\_ Referred by \_\_\_\_\_

Have you had acupuncture before?  Yes  No Have you had Chinese Herbs before?  Yes  No

Reason for Visit Today \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better / worse? \_\_\_\_\_

What do you feel needs to happen to relieve you of this condition? \_\_\_\_\_

Any additional health concerns \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you under the care of a physician now?  Yes  No If yes, for what diagnosis? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

Physician's Phone# \_\_\_\_\_ (we will not contact without your permission)

Other current therapies \_\_\_\_\_

Other therapies tried in the past \_\_\_\_\_

Any Pets? Y / N Type of Pets & general health \_\_\_\_\_

**Family Medical History** (indicate which: **Grandparents, Parents, Siblings, or your Children**):

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Alzheimer's   | <input type="checkbox"/> Gall Bladder issues | <input type="checkbox"/> Kidney stones       |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Inherited Disorders |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Depression          |



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**Your Past Medical History (includes you, only):**

- |   |  |   |  |   |
|---|--|---|--|---|
| <input type="checkbox"/> AIDs/HIV         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Surgery (list/date) | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Mumps              | _____  | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Pacemaker          | _____  | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Appendicitis     | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pleurisy           | _____  | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Thyroid Disorders   | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart Dz.           | <input type="checkbox"/> Polio              | <input type="checkbox"/> Major Trauma        | <input type="checkbox"/> Other (Specify)  |
| <input type="checkbox"/> Birth Trauma     | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatic Fever    | (Car accident, fall, abuse, war, etc.)       |   |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> High Blood Pressure |   | _____  | _____                                     |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Measles             | <input type="checkbox"/> Seizures           | _____  | _____                                     |
| <input type="checkbox"/> Kidney Stones    | <input type="checkbox"/> Gall Stones         | <input type="checkbox"/> Stroke             | _____  | _____                                     |

Your Diet: Appetite  Low  Moderate  High      Cravings:  Sugar  Carbohydrates

Salty food  Spicy food

Thirsty a lot?  Yes  No      Average # of glasses of water per day \_\_\_\_\_

**Typical Daily Menu:**

|                               |                           |                            |
|-------------------------------|---------------------------|----------------------------|
| Breakfast (approx time _____) | Lunch (approx time _____) | Dinner (approx time _____) |
| _____                         | _____                     | _____                      |
| _____                         | _____                     | _____                      |
| _____                         | _____                     | _____                      |

Snacks: \_\_\_\_\_

**Prescription Medications currently taking (indicate dosage, how many times per day):**

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**Vitamins/Supplements currently taking (indicate dosage, how many times per day):**

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**Musculoskeletal:**

- Neck/shoulder pain       Upper back pain       Joint pain       Limited range of motion  
 Muscle pain       Lower back pain       Rib pain       Limited use

Other (describe) \_\_\_\_\_  
 \_\_\_\_\_

**Skin and Hair:**

- Rashes       Eczema       Dandruff       Change in hair/skin texture      Other skin conditions \_\_\_\_\_  
 Hives       Psoriasis       Itching       Fungal infections      \_\_\_\_\_  
 Ulcerations       Acne       Hair loss      \_\_\_\_\_

**Neuropsychological:**

- Seizures       Poor memory       Irritability       Considered      Other (specify)\_\_\_\_  
 Numbness       Depression       Easily stressed      suicide      \_\_\_\_\_  
 Tics       Anxiety       Abuse survivor       seeing therapist      \_\_\_\_\_

**Genito-urinary:**

- Painful urination       Blood in urine       Venereal disease       Increased libido       Impotence  
 Frequent urination       Unable to hold urine       Bedwetting       Decreased libido       Premature  
 Urgent urination       Incomplete voiding       Wake to urinate       Kidney stone      ejaculation  
 Nocturnal emission

**Gynecology:**

- Age at first period      Duration of flow      Vaginal discharge       Breast lumps       Vaginal sores  
 \_\_\_\_\_years old      \_\_\_\_\_days      (color)\_\_\_\_\_       PMS       Vaginal odor  
 Length of cycle\_\_\_\_days (time between periods)       Irregular cycle       Painful periods       Clots  
 # pregnancies\_\_\_\_\_ # live births\_\_\_\_\_      Premature births\_\_\_\_\_
- Age at menopause\_\_\_\_years old       Date of last PAP\_\_\_\_\_       Date of LMP\_\_\_\_\_

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*Anything else?: Please provide further information about your current or past health concerns in the space below.*

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