



Points of Origin, PLLC
18810 NE 18th Street
Vancouver, WA 98684

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NEW PATIENT INTAKE FORM
(please feel free to attach any additional information)

Today's Date: ____/____/____

Name _____ Birth Date ____/____/____
Address _____ Marital Status _____ Age _____
City _____ State _____ Zip _____
 M F Ht _____ Wt _____ Occupation _____ Retired Y / N
Home Phone (____) _____ Work / Cell Phone (____) _____
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):

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 _____

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