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

Peter Hanfileti, MD
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Phone: 360-449-4500

NEW PATIENT REGISTRATION & INTAKE FORM Appt Date: _____/_____/_____
(please feel free to attach any additional information)

Name _____ Preferred Nickname _____
Mailing Address _____ City_____
State _____ Zip_____ Birth Date: _____/_____/_____ Age: _____
Gender:_____ Pronouns:_____
Ht_____ Wt_____ Occupation_____ Retired Y / N
Preferred Phone (circle) Work / Cell / Home # (_____)_____
How did you hear about us:_____
Preferred Email Address_____
Permission to Email / Call Appt Reminders: Y / N Permission to Email Receipts & Newsletter Y / N
Emergency Contact Name and Phone #_____
Health Insurance Name & Subscriber ID#_____
Primary Insured: Self or Name: _____ Birth Date: _____/_____/_____
Do you have Acupuncture Benefits? Y / N Subject to Deductible? Y / N Deductible Amount: $_____
Do you have an open personal injury (PIP), workman's comp or auto accident claim? Y / N
If Yes, provide details and contact info of claims adjuster: _____
_____
Have you had acupuncture before? Y / N Have you been prescribed Herbs before? Y / N
Reason for visit _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
On a scale of 0 to 10, how much does this impact your daily life? (0 is no impact and 10 is the most.)
Please Circle: 0 1 2 3 4 5 6 7 8 9 10
Describe how your life is most affected: _____
_____
_____
_____
Any additional health concerns_____
_____
_____

Are you under the care of a physician now? Y / N If Yes, for what diagnosis?_____
Name of your Primary Care Physician (PCP)? _____
Clinic Name & Phone#_____ Permission to contact your PCP: Y / N
Other current therapies_____
Other therapies tried in the past_____
Any Pets? Y / N Type of Pets & general health _____

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Family Medical History (i.e. significant illnesses that may run in your family.

_____
_____
_____

Your Past Medical History (include only your hospitalizations, illnesses, accidents, traumas, etc.):

_____
_____
_____
_____
_____

Prescription Medications currently taking (indicate dosage, how many times per day, when you started):

_____
_____
_____
_____
_____
_____
_____

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

_____
_____
_____

What best describes your dietary preferences (circle all that apply): Keto, Paleo, Vegetarian, Vegan, Plant-Based

Please describe the foods/drinks that are problematic to your health. (ex. sweets, gluten, alcohol, meat, etc)

_____
_____
_____
_____
_____

History of menstrual periods (e.g. regular/irregular, heavy/light flow, PMS, cramping, etc.) _____
_____
Date of Last Period: _____/_____/_____ Date of Last PAP: _____/_____/_____
History of pregnancies (e.g. miscarriages, infertility, c-sections, difficult births, etc.) _____
_____

To the best of my knowledge the information provided on this form is true and accurate.

Signature:_____

Printed Name:_____

Please do not write below this line. For office use only. Feel free to attach additional pages, documents or reports.