FIVE PIVOTS
CLINIC

Patient Intake

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Contact Information

NAME	PRONOUNS	DATE OF BIRTH	
EMAIL		NEWSLETTER OPT IN ☐ YES I would like to stay informed.	
MAILING ADDRESS			
PHONE Home		EMERGENCY Contact Name	EMERGENCY Contact Phone
PRIMARY PHYSICIAN		REFERRED BY	

Which treatments are you interested in having?

Further information can be found under 'Services' @ fivepivots.com

- ☐ Acupuncture
- ☐ Auricular (Ear) Acupuncture
- ☐ Cosmetic Acupuncture
- ☐ Facial Cupping
- ☐ Body Cupping / Guasha
- ☐ Energetic Healing
- ☐ Unsure

Primary Reason(s) for Your Visit

DATE OR PERIOD OF ONSET
DESCRIBE

List any other symptoms that are bothering you.

Do you have any of the following conditions? *Please check the appropriate boxes.*

Head, Eyes, Ears, Nose & Throat

- ☐ Headache
- ☐ Hair Loss or Other Issues
- ☐ Eye Pain / Strain
- ☐ Glaucoma
- ☐ Blurry Vision
- ☐ Floaters
- ☐ Sinus Problems
- ☐ Seasonal Allergies
- ☐ Nose Bleeds
- ☐ Ear Aches
- ☐ Ear Ringing
- ☐ Hearing Loss
- ☐ Sore Throat
- ☐ TMJ / Teeth Grinding
- ☐ Dental Problems

Respiratory

- ☐ Chronic Cough
- ☐ Frequent Colds
- ☐ Frequent Respiratory Infections
- ☐ Asthma
- ☐ Inhaler
- ☐ Smoker
- ☐ Pneumonia/Bronchitis
- ☐ Airborne Allergies

Cardiovascular

- ☐ Heart Disease
- ☐ Palpitations
- ☐ Dizziness
- ☐ Lightheaded Upon Standing
- ☐ Fainting
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Rapid Pulse
- ☐ Slow Pulse
- ☐ Varicose Veins
- ☐ Swelling of Ankles
- ☐ Cold Hands / Feet
- ☐ Blood Thinner
- ☐ Stroke
- ☐ Other (please describe)

Gastrointestinal

- ☐ Epigastric Pain
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Changes in Appetite
- ☐ Gas/Bloating
- ☐ IBS
- ☐ Liver/Gall Bladder Problems
- ☐ Hepatitis B or C
- ☐ Abdominal Pain
- ☐ Hernia
- ☐ Haemorrhoids
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Blood or Mucous in Stool
- ☐ Abdominal Surgery
- ☐ Food Allergies
- ☐ Special Diet

Urinary Tract

- ☐ Frequent Urination
- ☐ Incontinence / Leaking
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Frequent Infection
- ☐ Nighttime Urination
- ☐ Impaired Urination
- ☐ Kidney Stones
- ☐ Prostate Issues

Hormonal:
Menstrual / Fertility / Menopause / Transition

- ☐ HRT
- ☐ Premenstrual Symptoms
- ☐ Breast Tenderness
- ☐ Irregular Cycles
- ☐ Heavy/Painful Periods
- ☐ History of Pregnancy Complications
- ☐ Fertility Issues
- ☐ Trying to Conceive
- ☐ Libido Issues
- ☐ Mood Swings
- ☐ Hot Flushes
- ☐ Night Sweats
- ☐ Breast Cancer/Surgery
- ☐ Irregular PAP
- ☐ Vaginal Infections
- ☐ Sexually Transmitted Infection
- ☐ Erectile Dysfunction
- ☐ Testicular Pain

Endocrine

- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other Endocrine Disorders

Neurological System

- ☐ Poor Balance
- ☐ Dizziness/Vertigo
- ☐ Numbness
- ☐ Tingling
- ☐ Epilepsy
- ☐ Seizures
- ☐ Chronic Pain

Emotional

- ☐ Mood swings
- ☐ Stress/Tension
- ☐ Anxiety
- ☐ Panic
- ☐ Depression
- ☐ Obsessive Disorders
- ☐ ADD / ADHD
- ☐ Insomnia
- ☐ Other Sleep Issues

Other

- ☐ Low Energy/Fatigue
- ☐ Chronic Illness
- ☐ Rashes/Skin Disorders
- ☐ Bruising
- ☐ Chronic Infections
- ☐ Sensitivity to Hot/Cold Chills/Fever
- ☐ Cancer

Musculoskeletal

- ☐ Acute Pain
- ☐ Acute Injury
- ☐ Muscle Cramps
- ☐ Chronic Pain
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Other Systemic Disorder

Current Medications / Supplements / Vitamins

Medication/Supplement/Vitamin	Frequency	Duration	Dosage

ADDITIONAL NOTES if needed

Do you consume alcohol, cigarettes, or other altering substances?

My aim is to support you, my patient notes are confidential, and I will not judge.

Substance		Frequency	Dosage
Alcohol	☐ YES ☐ NO		
Cigarettes	☐ YES ☐ NO		
Altering Substance	☐ YES ☐ NO		

Please list any hospitalisations, surgeries or serious illness starting with the most recent and dating back to childhood.

Date	Hospitalisations / Surgeries / Serious Illness

Please list any accidents or injuries starting with the most recent and dating back to childhood.

Date	Accident / Injury / Trauma

Please list any important family medical history and / or notes on previous questions.

Please disclose any of the following. *I will treat you more safely with this information in mind.*

- ☐ Pregnancy
- ☐ Pacemaker
- ☐ Cancer (currently or in the recent past)
- ☐ Botox or Fillers in the past six months
- ☐ History of lymph node removal
- ☐ Bleeding disorder / bruise easily
- ☐ HIV, Hepatitis B or C

What other therapies have you tried for your main issue/s?

Date	Treatment

Have you had evaluations, scans or blood tests? *(You are welcome to bring results with you)*

Date	Evaluations / Scans / Blood Tests

Would you prefer to wear masks in the treatment room?

☐ **YES** ☐ **NO**

Disclaimer

Acupuncture involves the insertion of single-use, sterilised acupuncture-specific needles into areas of the body. Treatment may also include any of the following adjunctive therapies which are all within the scope of practice for licensed acupuncturists: acupressure (including ear seeds), moxibustion, dermal friction technique, cupping, mechanical, thermal, electrical, and/or electromagnetic treatments, dietary guidelines, therapeutic exercises and lifestyle counselling based on East Asian medical theory.

Most people only experience positive side effects, but due to the nature of acupuncture, mild to moderate negative side effects are also possible. Including, but not limited to, temporary discomfort at the site of the insertion of needles, swelling, bruising, bleeding, tingling, pain and / or 'nerve pain'. These normal responses can sometimes linger for a few hours or up to (rarely) several days. Please report anything like this at our next session.

Systematic responses such as nausea, fainting, dizziness or weakness can occur - especially if receiving treatment on an empty stomach. There may be *temporary* aggravation of the signs and symptoms that existed before the acupuncture treatment - this is called a "healing crisis" and is a sign the treatment is working. If you experience this I encourage you to avoid medication to treat these symptoms, rest and care for yourself as you would if ill, and contact me with any questions or guidance.

If possible, eat within a few hours of your session, and avoid drugs / coffee / stimulants / alcohol before your treatment. Feel free to contact me at any time if you have any questions or concerns.

I have read and understood the above statement.

DATE	SIGNATURE

General Data Protection Regulation (GDPR)

Five Pivots complies with GDPR guidelines by keeping personal data up to date; by storing, transporting, and destroying it securely; by not collecting or retaining excessive amounts of data; by protecting personal data from loss, misuse, unauthorised access and disclosure and by ensuring that appropriate technical measures are in place to protect personal data. Subscription to any newsletter or marketing emails can be terminated at any time by emailing info@FivePivots.com.

Confidentiality Policy

All patient information, including the fact of attendance to the clinic, is kept confidential and will only be released with consent of the patient. Patients have a right to access their own health records at any time by written request to info@FivePivots.com. Healthcare professionals are mandated to report certain disclosures of risk to self or others; if this raises questions for you, let's please discuss.

Cancellation Policy

Out of respect for my time and our patient-practitioner relationship, please give as much notice as possible if you are unable to make an appointment for any reason. Cancellations within 48 hours and no-shows may be charged between 50 - 100% of the regular fee.

I have read and understood the above statements.

DATE	SIGNATURE

Thank you for your time and background information; I look forward to working with you.