Title:_____Forename:_____Surname:_____

DOB:_____

Occupation:_____

Address_____

_____Post code_____

Tel No Home:_____Mobile:_____

Work:_____

Email:_____

We will only use your email to send promotions and newsletters, you can unsubscribe if you wish.

How did you hear of us?_____

Next of kin
Name:_____Relationship:_____

Contact Number_____

Have you ever had acupuncture before? Yes/No_____

The Follows pages contain questions relating to your current and past health. It is important you take your time to fill in the forms correctly so that your therapist can gain a clear picture of your health.
If you have any concerns about receiving Acupuncture please speak to your therapist about them before receiving treatment.

We thank you for your time and care in filling in the remaining forms.

Under each heading, please tick ONE box that best describes your health TODAY.

Mobility

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

Self care

I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

Usual Activities (e.g. work, study, housework, Family or Leisure activities)

I have no problems doing my usual activities ☐
I have slight problems doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

Pain/ Discomfort

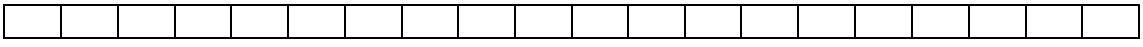
I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

ANXIETY/ DEPRESSION

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am Moderately anxious or depressed ☐
I am Severely anxious or depressed ☐
I am Extremely anxious or depressed ☐

We would like to know how good your health is TODAY.
On a scale of 0 to 100, where 100 means the best health you can imagine and 0 means the worst health you can imagine, please mark an x on the scale.

0 10 20 30 40 50 60 70 80 90 100



HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1-_____

2-_____

3 - _____

How is your sleep?_____

How is your digestion? _____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

□Diabetes □High blood pressure □Stroke

□Cancer □Heart disease □Kidney disease

Check symptoms you have or have had in the last year:

□ Depression
□ Difficulty in focusing
□ Dizziness
□ Easily startled
□ Excessive worry
□ Excessive anger
□ Excessive fear
□ Fatigue/tiredness
□ Headaches
□ Loss of sleep/poor sleep
□ Loss or gain of weight
□ Nervousness/irritability
□ Overwhelmed by life

Check conditions you have or have had in the past:

□ AIDS
□ Allergies
□ Anemia
□ Arthritis
□ Bleeding disorders
□ Breast lump
□ Cancer
□ Diabetes

How long has it been since you have had a complete medical exam? _____

OTHER HEALTH HISTORY

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- ❑ Tremors c Cramps
- ❑ Swollen joints

Pain, weakness, numbness in:

- ❑ Arms or Hips
- ❑ Back Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands
- ❑ Shoulders
- ❑ Other_____

CARDIOVASCULAR

- ❑ Chest pain
- ❑ Hardening of arteries
- ❑ High or low blood pressure
- ❑ Pain over heart
- ❑ Poor circulation
- ❑ Previous heart attack
- ❑ Rapid/irregular heart beat
- ❑ Swelling of ankles

Please continue overleaf

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ❑ Asthma/wheezing
- ❑ Blurred or failing vision
- ❑ Difficulty breathing
- ❑ Earache
- ❑ Enlarged glands
- ❑ Eye pain
- ❑ Frequent colds
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Gum trouble
- ❑ Nose bleeds
- ❑ Loss of hearing
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems

SKIN

- ❑ Boils
- ❑ Bruise easily
- ❑ Dry skin
- ❑ Itching/rash
- ❑ Sensitive skin
- ❑ Sore won't heal
- ❑ Sweats

GENITO/URINARY

- ❑ Blood/pus in urine
- ❑ Frequent urination
- ❑ Inability to control urine
- ❑ Kidney infection/stones
- ❑ Lowered libido

GASTROINTESTINAL

- ❑ Belching, gas or bloating
- ❑ Colon trouble
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty swallowing
- ❑ Distention of abdomen
- ❑ Excessive hunger
- ❑ Gall bladder trouble
- ❑ Hemorrhoids (piles)
- ❑ Indigestion
- ❑ Nausea
- ❑ Pain over stomach
- ❑ Poor appetite
- ❑ Vomiting

FOR MEN ONLY

- ❑ Erection difficulties
- ❑ Penis discharge
- ❑ Prostate trouble

FOR WOMEN ONLY

- ❑ Bleeding between periods
- ❑ Clots in menses
- ❑ Excessive menstrual flow
- ❑ Extreme menstrual pain
- ❑ Irregular cycle
- ❑ Menopausal symptoms
- ❑ PMS
- ❑ Previous miscarriage
- ❑ Scanty menstrual flow

Could you be pregnant?_____

SIGNATURE

I have read/ will read the information leaflet fully so that I am aware of what to expect from treatment.

The information on this form is correct to the best of my knowledge and I am happy to proceed with treatment.

Signature_____ Date _____