

 **Confidential Health Questionnaire**

Name: Date:

Address:

Email address

Mobile phone number

Occupation:

Date of birth / age

Relationship status

Which GP are you registered with?

In preparation for your acupuncture session, please fill in this questionnaire.

It will save a lot of time at your first session and doing the questionnaire at home allows you to relax, remember, and record everything that you may feel to be relevant to your condition.

Please skip any sections that may not be relevant to you and feel free to attach extra sheets if you think it might be helpful. Your information will be treated in the strictest confidence according to our privacy policy which can be downloaded from www.wellnessdumfries.org

|  |
| --- |
| **Why have you come for treatment?**1.2.3. |
| 1. **Main complaint**
 |
|  When did it start? |
|  What makes it better / worse |
|  If pain, how would you describe it? |
|  How will you know you are getting better? |
|  What other treatments are you having / have tried? |
| **Medical History**: Any past surgery, serious illness, infections, accidents / injuries with approximate dates: |
| What stresses have you experienced in your life such as bereavements, divorce, parents’ split-up, redundancy etc.? |
| Any current ongoing stress such as relationship problems, work issues, family issues etc.? |
| **DIET**: |
| Breakfast |  |
| Lunch |  |
| Evening Meal |  |
| Between meals |  |
| What do you do for exercise and relaxation? |  |
| **Medication**: |
| Are you currently taking any medications? Please state the name and dosage.Use overleaf if necessary> | Y / N |
| Have you reacted to any medication? If so, what was it and what symptoms manifested? | Y / N |
| Do you smoke?If yes – how many a day? | Y / N |
| Do you drink alcoholIf so – how much a week?Do you drink Tea /Coffee/ fizzy drinks? | Y / N |
| Do you use recreational drugs?If so – what and how often?If not now, have you in the past?If so what and for how long? | Y / NY / N  |

|  |  |  |
| --- | --- | --- |
| **Ailment/Symptoms**  | **This symptom/ state of health is relevant to me currently.****Tick box and description** | **This is a symptom/state of health I have had in the past, but it is not currently an issue****Tick box and description** |
| Poor sleep |  |  |
| Anxiety |  |  |
| Irritability |  |  |
| Mood swings |  |  |
| Depression |  |  |
| Over thinking |  |  |
| Low mood |  |  |
|  |  |  |
| Pain: Neck/Shoulders |  |  |
| Pain: mid back |  |  |
| Pain: Lower Back |  |  |
| Pain: Joints  |  |  |
| Pain: other |  |  |
|  |  |  |
| Poor appetite |  |  |
| Food Cravings |  |  |
| Abdominal bloating |  |  |
| Poor digestion |  |  |
| Constipation |  |  |
| Loose bowels |  |  |
| Food allergies |  |  |
| Fungal infections |  |  |
|  |  |  |
| Fluid Retention |  |  |
| Poor circulation |  |  |
| Eye Problems |  |  |
| Headaches |  |  |
| Migraines |  |  |
| Dizziness |  |  |
| Fainting |  |  |
| Fits (Epilepsy) |  |  |
| Tremors /Twitches |  |  |
|  |  |  |
| Sore throats |  |  |
| Sneezing |  |  |
| Runny Nose |  |  |
| Runny / itchy eyes |  |  |
| Stuffy Sinuses |  |  |
| Cough/wheezeBreathing problems |  |  |
| Frequent colds and infections |  |  |
| Hay fever/allergies |  |  |
|  |  |  |
| Chest pain /palpitations |  |  |
| Frequent Urination |  |  |
| Urinary Infections |  |  |
| Up at night to urinate |  |  |
| Swollen ankles |  |  |
| Low Libido |  |  |
| Sweating at night /day |  |  |
| Cold extremities |  |  |
| Hot hands and feet |  |  |
| Thirst  |  |  |
| Skin rashes/spots |  |  |
|  |  |  |
| **Female Health Questions** |  |  |
| Problems with monthly periods |  |  |
| Irregular |  |  |
| Painful |  |  |
| Light  |  |  |
| Heavy |  |  |
| Painful |  |  |
| PMT |  |  |
| Are You Pregnant now? |  |  |
| Successful Pregnancies  |  |  |
| Terminations/Miscarriage |  |  |
| Infertility  |  |  |
| IVF |  |  |
| Contraceptive Pill |  |  |
| Menopausal Problems such as hot flashes |  |  |
| HRT/ natural remedies |  |  |
|  |  |  |
| **Do you suffer from any of the following** |  |  |
| Hepatitis |  |  |
| Aids/HIV |  |  |
| High or Low Blood Pressure |  |  |
| Epilepsy |  |  |
| Cancer |  |  |

 **Please fill in your name, read and sign the following statement**:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that by its very nature acupuncture and other modalities of Chinese Medicine (including, but not exclusive to, the following: acupressure, Tui na, moxibustion, cupping, electrical stimulation and Gua sha), may cause minor discomfort and may irritate the skin or leave small bruise.

There are cases where symptoms may get worse before they get better, and I understand that if my condition worsens, I should get in touch with the treating practitioner and/or seek other appropriate medical care.

I realise that no claims, promises or guarantees are being made for the risk and effectiveness of all treatment.

I understand that any information I give my practitioner will be held in strict professional confidence within the clinic.

I understand that my personal details will be stored in line with the Data Protection Act.

I understand that I will be unable to donate blood for four months after I have finished a course of acupuncture treatment.

I acknowledge that the practitioner may refuse me treatment if it is felt that my medical condition requires referral to a medical doctor.

**I will disclose if I have any of the following conditions: cancer, epilepsy, diabetes, high/ low blood pressure, haemophilia, pregnancy, hepatitis, AIDs or another contagious disease.**

I will also disclose details of any medication I am taking.

I understand that if I am deemed to be under the influence of alcohol or illegal drugs, I may be refused treatment.

I understand that if **I cancel my appointment**, without giving a **minimum of 24 hours’ notice**, that I will incur a charge.

Signed: Date