

 **Confidential Health Questionnaire**

Date:

Name:

Address:

Email address

Mobile Phone

Occupation:

Date of birth / age

Relationship status

Which GP are you registered with?

|  |
| --- |
| **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 alcohol?If 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 patient currently.****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 |  |  |

Any other relevant information…

 **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 able to donate blood after acupuncture (please ask for AAC number)

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