|  |  |
| --- | --- |
| **Name:** | **Date:** |
| **Address:** | **GP:**  **GP Clinic Address/phone:** |
| **Tel No:** | **Email:** |
| **Occupation:** | **Date of Birth:** |
| **Named Contact (in case of emergency):**  **Tel no:** | |

**SECTION 1: HEALTH ISSUE and MEDICAL HISTORY**

**Main complaint/what you hope to achieve with acupuncture:**

**When did it start?**

**Is it constant/occasional/intermittent?**

**What aggravates it?**

**What gives you relief?**

**In what way does it affect you day to day (e.g. pain intensity/frequency, managing tasks/work/hobbies/mood/sleep etc.)?**

**Have you discussed this with, or been treated by any of the following?**

GP  Physiotherapist  Osteopath

Chiropractor  Acupuncturist  Complementary therapist

Fertility clinic  Massage or manual therapist

Consultant:        Other

**Relevant Medical tests**

**Relevant Medical Diagnosis**

**Previous surgery or treatments**

**List Medications**

**Health Supplements?**

**Do you have any other current (or previous) significant illnesses?**

**SECTION 2: MEDICAL AND SAFETY**: *Please tick ALL that apply:*

* **Blood Pressure**:  High Low Normal
* **Clotting/Bleeding**:  Blood thinning medication?

Haemophilia or blood clotting disorder?

* **Heart**:  Heart Condition (state diagnosis)

Pacemaker?

* **Neurological history:** Spinal injury , Head injury , Epilepsy ,

Any other diagnosed neurological problem?

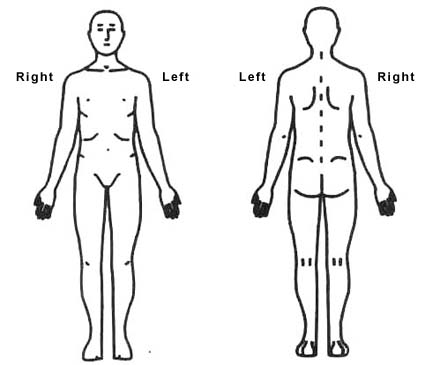
* **Headaches** **, migraines**
* **Infectious disease:** Hep A , Hep B , HIV ,

Other transmittable infection

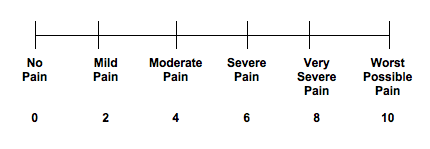
* **Possibility of Covid-19 infection?**  yes  no
* **History of Cancer**
* **Allergies (list)**  **Possibility of pregnancy**
* **Upcoming medical appointments** **, or surgery** **?**
* **Is there anything else you think we should know about?**

**SECTION 3: PAIN symptoms (hand written copies only)**

1. If you can, mark on the diagram where you experience pain.



2. If you can, mark your typical pain intensity on the following scales:

****

**SECTION 4: General health (Chinese medicine)**

Select any of the following that may have experienced recently, rating from 0 (never) to 5 (most severe or frequent):

**Gan**

Irritability/frustration Depression or low mood

Anxiety or stress Emotional eating

Red/Dry/Itchy eyes Headaches

Migraines Dizziness

Feeling lump in throat Feeling pain under ribcage

Muscle spasms Neck/shoulder tension

Feel like sighing Painful periods/PMS

**Xin**

Feeling like palpitations Chest pain

Insomnia/sleep issues Restlessness/agitation

Vivid dreams Lack of joy in life

Forgetful Aversion to heat

**Shen**

Bladder infections Frequent urination

Wake to urinate Lack of bladder control

Night sweats/hot flashes Feeling cold easily

Hearing problems Tinnitus

Ankle swelling Low back pain

Painful/weak knees Dark/scanty urine

Thirst (prefers cold) Thirst (prefers warm drinks)

**Fei**  Fever/chills

Dry cough Productive cough

Nasal discharge/drip Sinus infection

Nasal congestion Sore throat

Skin rash/itch Allergies/asthma

Shortness of breath Poor immune system

**Pi**

Issues triggered with certain foods (list):

Feeling of heaviness/tiredness in the body

Difficulty getting up in the mornings

Fatigue after eating Water retention

Bruises easily Hemorrhoids

Poor appetite Craving sweets

Poor digestion Nausea

Bloating/gas Constipation

Alternating constipation/loose stool Loose stools

Intestinal pain/cramping Heartburn

Overweight Aversion to cold

Sweat easily Overthinking

Difficulty concentration/brain ‘fog’ Yeast infections

Is there anything else that might be relevant?

**Other lifestyle notes**:

* How do you keep active?
* What is your daily energy like from 1-10?
* diet,
* relaxation
* alcohol
* tobacco
* Another other comments:
* menstrual cycle (e.g. regular/irregular/other issues):

What will be the main benefit in your life when you recover from or learn to gain control of your health issue?

**Your statement of consent**:

1. I confirm that the information I have provided is accurate to the best of my knowledge, and that I consent to the use of this information as described in the Data Privacy Notice (summary).
2. I have received and read the information about acupuncture, possible side effects and safety procedures under **COVID-19**
3. I understand the **fees** and the **cancellation policy** of £20 for less than 24 hours notice.
4. I consent to treatment, and I understand that I can ask my practitioner anything regarding my treatments, expectations and goals.

**Signed:**       **Date** :

You have finished! ☺ Thank you for your patience in completing this form. We hope that you enjoy your first treatment.

***Data Privacy Notice (summary):*** *As a new client of Belfast Community Acupuncture we need to advise you how we will be using your personal information in order to comply data protection (GDPR 2018). Belfast Community Acupuncture will collect and process your personal information to allow us to contact you and to plan and review your treatments. We will only use your personal information for the purpose for which it was collected. We will not share your information with anyone else unless it is with your written permission or there is a legal or ethical duty for us to do so. Under Covid-19 we are expected to document extra information, which is protected by the same data laws. In the event of a Covid-19 incident we may be required to pass on your contact details for the purpose of contact tracing. You can find further details on the collection and processing of personal information and the rights you have in relation to your personal information in our Data Protection and Confidentiality Policy on our website at: www.belfastcommunityacupuncture.com; hard copies on request.*

Therapist Notes (TCM /Clinical Opinion/Treatment Given/Feedback/etc.)

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