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 are you initial goals from 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 0-10, 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: HEALTH & SAFETY: *Please tick ALL that currently apply:*

- **Blood Pressure**: ☐ High ☐Low ☐Normal ☐Unknown
- Do you have a **blood clotting disorder**? Y☐/ N ☐
- Are you prescribed blood thinning medication? Y☐/ N ☐
- **Heart**: Heart Condition Y☐/ (state diagnosis) N ☐
  Do you have a pacemaker or electrical implant device? Y☐/ N ☐
- **Neurological:** Spinal injury ☐, Head injury ☐ Epilepsy/seizures ☐,
- Any other diagnosed **neurological** problem? Y☐/ N ☐
- **Headaches** Y☐/ N ☐**, migraines** Y☐/ N ☐
- **Infectious disease:** Hep A ☐, Hep B ☐, HIV ☐,
  Other transmittable infection Y☐/ N ☐
- **History of Cancer** Y☐/ N ☐
- **Allergies (list)**
- **Possibility of pregnancy Weeks**
- **Upcoming medical appointments** Y☐/ N ☐**,**
- **Planned surgery** Y☐/ N ☐
- **Is there anything else you think we might need to know?**

SECTION 3: Symptoms:

1. Please describe your symptoms in your own words:

SECTION 4: General and holistic health

The following lists some a range of symptoms that may be considered as part of a holistic assessment. You do not have to complete this section but it can help to have a picture of overall health. Please check any that apply.

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 or tightness
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

Feeling of heaviness/tiredness in the body

Difficulty getting up in the mornings

Fatigue after eating	Water retention
Bruises or bleeds easily	Hemorrhoids
Poor appetite	Craving sweets
Poor digestion	Nausea
Bloating/gas esp. after eating	Constipation
Alternating constipation/loose stool	Loose stools
Intestinal pain/cramping	Heartburn
Overweight	Aversion to cold
Sweat easily	Tend to overthink things
Difficulty concentration/brain 'fog'	Recurring yeast infections

Are you aware of particular foods or triggers of digestive symptoms? (list):

Please list any other symptoms:

Other lifestyle notes:

- exercise routine/physical activity:
- daily energy levels (low to high) 1-10
- how do you feel about your diet,
- How do you relax?
- Do you take alcohol☐, tobacco☐ Comments:
- menstrual cycle: regular ☐ irregular ☐ PMS ☐ no periods ☐ perimenopause ☐ post-menopause ☐
- Are there any other issues, or anything you wish to discuss?:

Your statement of consent:

1. I confirm that the information I have provided is accurate and complete to the best of my knowledge, and that I consent to the use of this information as described in the Data Privacy Notice (summary below).
2. I understand the **fees** & the **cancellation policy (**minimum 24 hrs notice).
3. I understand that I can ask my practitioner anything regarding my treatments, expectations and goals.
4. I consent to treatment at this stage.

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. Please note that third party apps e.g. email or internet providers cannot be guaranteed to be secure. You can also print this form or complete a paper copy at the clinic prior to your appointment. 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.*