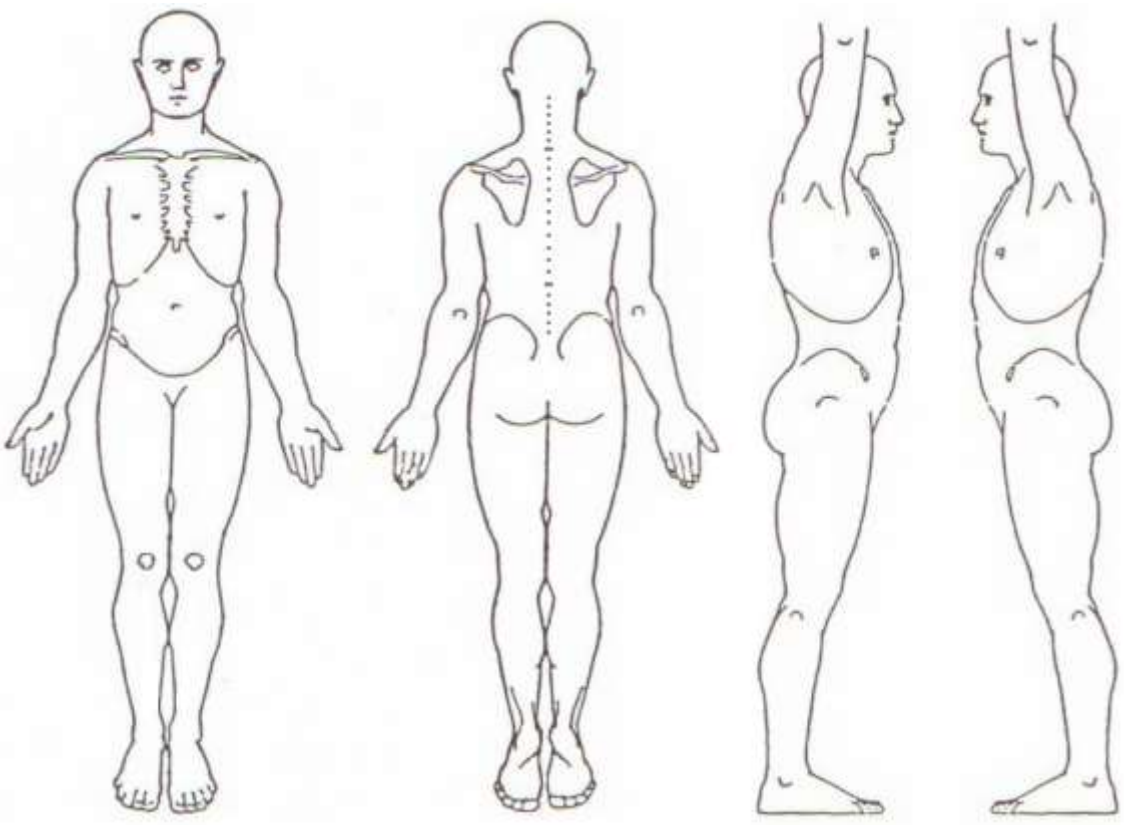
Patient Questionnaire – Austin Acupuncture

Name:		DOB:		Case #:	

Please complete this form as fully as possible, attach extra sheets and test results or other information that you think may be useful. Don't worry if you are unable to complete the form, we can complete it during the consultation but this may reduce the time available for your first treatment.

List your complaints - Use the diagram below to mark where it hurts, etc.



List all medication you are taking. If you prefer you can attach a list or bring your prescription for us to copy		
Drug name	**What are you taking it for and when did you first start taking it**	**Date**

Do you suffer from or have ever suffered from any of the following?			
Condition	**Yes**	**No**	**Since when - Date**
Heart condition / angina			
Blood pressure problems			
Epilepsy / seizures			
Haemophilia / blood clotting disorders			
Blood borne virus, e.g. Hepatitis B / C or HIV			
Skin complaints, e.g. psoriasis, eczema			
Diabetes, type 1 or type 2			
Allergic response, e.g. pollen, jewellery			
Blood-thinning medicines, e.g. warfarin or aspirin			
Could you be pregnant			

Medical history - List all previous operations and significant illnesses or disorders	
Previous operations, illnesses or disorders	**Since when**

Consent & Cancellation Policy

Sign and date in the clinic on the day of the consultation

I (the patient) confirm these details are correct and I consent to treatment as discussed and agreed between myself and my therapist, or; I am the legal guardian and I consent to my charge having treatment as discussed and agreed between myself and the therapist.

I understand a cancellation fee of £10 will be charged if the appointment is cancelled with less than 24 hours' notice, or the full fee will be charged if the appointment is unattended with less than 24 hours' notice.

I confirm that I have been told about potential side effects and have been given a patient information form.

Signature: _____ Date: _____

Patient Details – Austin Acupuncture

Name: _____

Address: _____

_____

_____

Post Code: _____

Tel. Home: _____

Tel. Mobile: _____

Email: _____

Date of Birth: _____

Age: _____

Occupation: _____

Height (if known): _____

Weight (if known): _____

Medical practice: _____

Doctor's name: _____

Medical insurance company (if applicable): _____

May we contact your doctor (we do not notify your doctor as standard practice): _____ Yes / No

How did you hear about Austin Austin Acupuncture: _____