**ACUPUNCTURE QUESTIONNAIRE AND CONSENT FORM**

**PATIENT DETAILS**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT MEDICAL HISTORY**

**Do you (Does the patient, if completing for an under-16) currently suffer from, or have you (they) ever suffered from any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Details |
| 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 |  |  |  |
| Allergic response, e.g. anaesthetics, jewellery |  |  |  |
| Do you regularly take any blood-thinning |  |  |  |
| medicines, e.g. aspirin? |  |  |  |
| Do you take any regularly prescribed medication? |  |  |  |
| Could you be pregnant? \* |  |  |  |
| \*Have you consulted your midwife on acupuncture? |  |  |  |
| Details of any associated problems with treatment |  |  |  |

**I declare that the information I have provided on medical history is correct to the best of my knowledge and hereby give consent for acupuncture to be carried out by the practitioner. I confirm that I have been informed of potential complications that are sometimes associated with the procedure and appropriate aftercare that may be required. I give consent to the practitioner to retain the details provided on this form for a period of 7 years from today. The details will not be shared with a 3rd party without your consent.**

**Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_\_**

**Where patient is under 16 years old, details and consent of parent or guardian:**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Proof of ID provided? Y N**

**Signature of Parent or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_**

**Signature of Practitioner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_\_**

**General Comments and feedback:**