**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 medication? e.g. aspirin? |  |  |  |
| Covid19? |  |  |  |
| 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 Data Protection Regulation (GDPR) Consent Form:**

**As clinic customer we may occasionally send you texts or emails to inform you about your treatments or appointment booking changes or important changes to our services that may affect you. To continue to provide you with important updates on your treatments and booking times we request your consent / opt-in to stay in touch with you. We will never provide your details to a 3rd party or send you marketing information.**

**Yes: opt me in Sign here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any additional information you wish to add:**