Heidi Bader

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HB acupuncture

Thank you for your interest in acupuncture. Your practitioner aims to provide a high standard of care and needs information regarding your past and present health. This will determine the most appropriate treatment for you. Please print as clearly as possible. Your answers are confidential and subject to the 1998 Data Protection Act.

Name.. Date of Birth ..../.........../.............

Address...
....
....
Postcode:...

Contact Tel No:...

Mobile:...

E-mail:...

Occupation:...

Main Complaint:
....

Secondary complaint:

....

In your own words please describe the problem you are presenting with. Say how it makes you feel, how it limits you and what you hope to achieve from treatment.

....
....
....
....
....

Duration:.. Dates from...................................To...............................

Current medical treatment..

Please list any medical examinations/investigations you have had e.g. blood/stool tests, ECG, endoscopy, scans, etc. and significant results.

....Date......./........./..........Result...

....Date......./........./..........Result...

....Date......./........./..........Result...

Personal Health History

Health problem	Age started	Management	Duration
Example: migraines	25yrs	Migrileve/Paracetamol	18yrs

Parents' Health
Mother:
Father:

Please list your current medication (if any) including HRT/birth control

Name/Dosage	Function	Duration

Are you currently taking any vitamin, minerals, herbs and other supplements?

Please list..

Allergies..

Accidents: injuries: operations: broken bones? Hospitalisation?	Age/Date

As far as you are aware have you ever had any of the following diseases?

	Yes	No		Yes	No
Measles			**Meniere's**		
Mumps			**TB**		
Chickenpox			**Diphtheria**		
Rheumatic Fever			**Malaria**		
Whooping Cough			**Hepatitis**		
Legionnaire's Disease			**ME**		
Meningitis			**HIV**		
MRSA					

Your weight .... Your height ....

BMI ....

Immunisations: BCG/MMR...

Problems in childhood?

...

...

Are you a smoker?......................... How long?..........................

	Yes	No
Are you epileptic?		
Are you diabetic?		
Do you have a heart condition?		
Do you have a pacemaker or other electrical implants?		
Are you taking anti-coagulants/warfarin?		
Do you have damaged heart valves or have any particular risk of infection?		
Do you have your blood pressure checked regularly?		

Do you exercise regularly .... **How often?...............................**

THIS SECTION IS FOR WOMEN ONLY

FOR MOTHERS

Please comment on number of pregnancies, experiences during pregnancy and labour. E.g. back pain, epidural, caesarean section, high blood pressure etc.

....
....
....

Name/Address of GP..

...Postcode.........................

Tel No:..

Do you give permission for your medical doctor to be contacted?.................................

Thank you for completing this form.

Your practitioner will ask you for more details during the consultation.

To the best of my knowledge all statements made in this case history are true.

Signed...Dated...

If you are signing on behalf of a minor please print your full name and give your relationship to the patient.

Full name...Relationship...

Cash and Cheque only

Please check with your insurance company for cover of acupuncture treatment.