Heidi Bader Traditional Acupuncture Lic Ad MBAcC

Thank you for your interest in acupuncture. Your Practitioner aims to provide a high standard of care. The initial consultation involves a detailed medical history which lasts one and a half hours (in addition to the information you provide on this form), including details of your main complaint, your past and present health and lifestyle. From this, a treatment plan is put together for you which is reviewed as treatment progresses. The initial consultation involves an acupuncture treatment. Please print as clearly as possible.

Your signature will be required on the printed copy of your form on the initial consultation.

Please see the Privacy Notice on my website (directly under 'contact details') regarding processing your personal data. Your answers are confidential and subject to the Data Protection Act 2018, which includes the General Data Protection Regulation (GDPR).

Name:	
Date of Birth:	
Your Address:	
Postcode:	
Mobile:	Email:
Occupation:	
Main Compliant	
Secondary Complaint	

Complaint Details:

In your own words please describe the problem(s) you are presenting with. Say how it makes you feel, how it limits you and what you hope to achieve from treatment? (Max 1000 chars).

Duration of your Complaint: (M = Main S = Secondary)

Date from: (M)		Date to:	
Date from: (S)		Date to:	

Current medical treatment:

Please list any medical examination/investigations you have had e.g. Blood/Stool tests, ECG, Endoscopy, Scans etc. and significant results?

Examinations / Investigations:	Date:	Results:

Personal Heath History

Health Problem	Age Started	Management	Duration
Example: Migraines	12 years	Migrileve/Paracetamol	10 Years

Parents Health (Known Genetic issues if applicable) Max 1000 Chars

Mother	
Father	

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

Name:	Dosage:	Function:	Duration:

Please list any Allergies:

Please list Accidents/ Injuries / Operations / Broken Bones / Hospitalisation:

Events:	Age	Date

As far as you are aware have you ever had any of the following diseases? Yes or No.

Diseases	Yes	No
Measles		
Mumps		
Hepatitis		
ME		
Chickenpox		
Whooping Cough		
HIV		
MRSA		

	Imperial	Metric
Your Weight (Imperial or Metric as you prefer)		
Your Height		
Your BMI		

Immunisation:	Yes	No
BCG		
MMR		

Problems in childhood? (Max 1000 chars)

Smoking

	Yes	No
Do you Smoke?		
	Years	
How long have you smoked?		

Health Questions:	Yes	No
Are you Epileptic?		
Are you Diabetic?		
Do you have a heart condition?		
Do you have a Pacemaker or other electrical implant?		
Do you have damaged heart valves or at any particular risk of infection?		
Do you have your blood pressure checked regularly?		
Are you taking anti-coagulants/warfarin?		
If Yes to the above, do you know your INR number?		
Exercise	Yes	No
Do you Exercise regularly?		
If Yes to the above, how often? (Times per week)		
Diet:	Your Answers:	
How many portions of Vegetables do you consume per day?		
How many portions of fresh fruit do you consume per day?		
Do you eat meat?		
If you are a vegetarian, what is your protein source?		
Do you eat dairy products?		
Do you eat sugary foods?		
Do you eat Grains/Pulses?		

For Women Only:

	Yes	No
Do you think you may be pregnant?		
If you have stopped Menstruating, when was your last period (Approx)		
Please advise the number of pregnancies you have had?		

Mothers:

Please comment on your experiences during pregnancy and labour. e.g. Back Pain, Epidural, Caesarean Section, High Blood Pressure etc. Max 1000 Chars

Your Doctors Details:

Doctors Name:	
Practice Name:	
Address:	
Postcode:	
Telephone:	

Please provide 24 hours advance notice if you need to cancel your appointment.
If less than 24 hours notice is given the full fee is charged.
No show appointments will be charged the full fee.

Signature: Date:

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.

Please check the box indicating if you are happy to receive occasional newsletters, special offers or vouchers via email? *Please note that your contact details will never be passed to a 3rd party.*

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

Full Name Your Relationship

Cash or cheque only. Please do check with your insurance company for cover of acupuncture treatment.
Please email your completed form to heidi.bader@hbacupuncture.co.uk