Full Circle Health
A complete approach

FULL CIRCLE HEALTH NEW PATIENT INFORMATION: ACUPUNCTURE
This information is held confidentially and will not be shared with any third parties. Traditional Chinese Medicine looks at the whole person rather than a collection of symptoms. The following form is an invaluable detailed list to help me, as your practioner, devise treatments for you as a unique individual.

From time to time it may be necessary to contact you by email; by signing at the end of the form you are giving your consent for Full Circle Health to use your email for correspondence.

Thanking you for writing clearly.

Patient Information	Contact Information
Name: Address: Date of Birth: G.P: Occupation: Marital Status: Children:	Telephone: Mobile: Landline: Email: Emergency Contact person: Name & relationship to you. Contact number
Health History Reasons for treatment: Please describe your current health issues. 1) 2) 3) Have you consulted your G.P about this?	Tick any symptoms you have had in the last year: ○ Depression ○ Anxiety ○ Panic Attacks ○ Nervousness ○ Irritability/ Anger ○ Dizziness ○ Fatigue/Tiredness ○ Poor Sleep ○ Insomnia ○ Headaches

Medications you currently take:

Please list **all** serious illness, accidents, operations and other significant shock or traumatic events.

Tick Conditions in blood relatives:

- Diabetes
- Cancer
- Heart Disease
- Stroke
- Kidney Disease

Tick conditions you have had had in the past:

- Heart disease/Heart Attack
- Cancer
- Diabetes
- Anaemia
- Bleeding disorders
- Asthma
- Arthritis
- Allergies
- Infectious disease i.e. HIV, Hepatitis

Health Issues continued

- Migraines
- Mood Swings
- Loss or gain of Weight
- Excessive Worry

Muscles/Joints/Bones:

- Cramps
- Shaking or Tremors
- Numbness or Tingling
- Swollen Joints
- Aching Joints

Pain or other problems in:

- Lower Back
- Upper Back
- Neck
- Shoulders
- Arms
- Feet/Ankles
- Hands/Wrists
- Other:

Health History Continued – symptoms you've had in the last 12 months:

Sleep:

- Insomnia
- Difficulty in falling asleep
- Waking at night
- Waking very early
- Sleep disturbed by dreams
- Waking feeling un-refreshed
- The need for too much sleep.
- Nightsweats

- ENT/Respiratory:
- Asthma
- Wheezing
- Difficulty breathing in or out
- Shortness of breath
- Persistent Cough
- Frequent colds
- Hayfever
- Sinus problems
- Nose Bleeds
- Dry, running or sore eyes
- Red or itching eyes

- Loss of hearing
- Gum disease
- Eye Floaters
- Tinnitus/ ringing in the ears
- Earache
- Yellow eyes or failing vision

Skin:

- Eczema
- Psoriasis
- Itching/rashes
- Dry skin
- Bruise easily
- Boils or sores
- Other

Urinary:

- Frequent urination
- Bladder infection/urethritis
- Blood in urine
- Pain on urination
- Urgency
- Kidney infection/stones

Digestive/Bowels:

- Constipation
- Diarrhoea
- Loose stools
- Haemorrhoids (Piles)
- Flatulence/wind/burping
- Pain in stomach/abdomen
- Bloating
- Nausea
- Indigestion
- Poor appetite
- Excessive Hunger
- Vomiting
- Other

Women Only:

- Severe period pains
- Length of periods
- Absent periods
- Number of days between each period
- Pale or dark blood
- Fertility issues*please ask for separate sheet

Women Only continued:

- Heavy periods
- Bleeding between periods
- Menstrual clotting
- PMT
- Sore breasts
- Thrush
- Recurrent BV
- Discharge
- Number of pregnancies
- Could you be pregnant?
- Menopause
- What age do you reach the menopause?

Associated Symptoms: Hot flushes/nightsweats/ forgetfulness, anxiety, insomnia, irregular bleeding, dry vagina, reduced libido
Other

Men Only:

- Prostate trouble
- Erectile Dysfunction
- Lowered libido
- Low Sperm Count
- Fertility issues*Please ask for separate sheet
- Other

General:

- Do you have cold hands and or feet?
- Do you have a constant thirst or dry mouth during the day or night?
- Do you generally feel hot or cold?
- Do you experience spontaneous daytime sweating?
- Do you have a certain taste in your mouth?
- How are your emotions in general; Balanced Erratic Other
- Regular emotional states: e.g. Happy/sad/content/fearful/

General continued: worried/hopeless/anxious, nervous/calm/confident/shy/stressed weepy/frustrated, etc ○ Alcohol Intake Yes/No how much ○ Smoking Yes/No How much Caffeine intake? Yes/No How much? Exercise: Yes/No How often?	Anything else you would like to discuss?

Signature & Consent:

I confirm that I've read and understood the 'What you really need to know about Acupuncture with Helen Cockle' of Full Circle Health sheet: ☐ please tick

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation,

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days. Also dizziness or fainting can occur in some cases.

Slight superficial burns and temporary marks are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping.

Very unusual risks of acupuncture could include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax).

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. All my information will be kept confidential. However my named acupuncturist may contact my GP if deemed necessary. I consent to be contacted via email by Full Circle Health.

Signed The patient or patients representative Signed Named Acupuncturist.	Date Date