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Full Circle Health
A complete approach

FULL CIRCLE HEALTH NEW PATIENT INFORMATION/ CONSENT FORM: ACUPUNCTURE

This information is held confidentially and will not be shared with any third parties. Traditional Chinese Medicine (TCM) looks at the whole person rather than a collection of symptoms. The following form is an extremely useful and detailed list based on TCM principles to help me devise your treatments.

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.

Name of premises: _____

Address of premises: _____

Registered Person no: _____

Today's date: _____

PATIENT INFORMATION

Name: _____

Address: _____

Date of Birth: _____ **G.P:** _____

Occupation: _____

Marital Status: _____ **Children:** _____

CONTACT INFORMATION

Telephone: _____ **Mobile:** _____

Landline: _____ **Email:** _____

Emergency Contact person:

Name & relationship to you. _____

_____

Contact number: _____

HEALTH HISTORY

Reasons for treatment: _____

_____

_____

_____

Have you consulted your G.P about your reasons for seeking treatment? ☐ Yes ☐ No

	Health Issue	Yes	No
1.	Is GP's consent required	☐	☐
2.	Date GP's consent obtained if required.	☐	☐
3.	Any special medical and or other information		

Medications you currently take:

Including antihistamines, steroids and cancer treatments drugs.

Please state whether you are on any blood thinning medication such as aspirin.

1.	
2.	
3.	
4.	
5.	
6.	

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

1.	
2.	
3.	
4.	
5.	
6.	

Vitamins/ Supplements you are currently taking:

TICK CONDITIONS YOU HAVE HAD IN THE PAST. PLEASE LIST WHEN YOU HAD THESE:

☐ Anaemia ☐ Asthma ☐ Earache
☐ Eye Floaters ☐ Gum disease ☐ HIV, Hepatitis B or C
☐ High blood pressure ☐ Loss of hearing ☐ Low blood pressure
☐ Psychiatric events or a named disorder ☐ Tinnitus/ ringing in the ears
☐ Haemophilia and other bleeding disorders. ☐ Implants as a result of surgery/artificial joints
☐ Yellow eyes or failing vision.
☐ Heart disease ☐ Heart attack
☐ Heart condition (inc: Angina,Pacemakers, Stents etc) _____
☐ Allergies, (inc: plasters) _____
☐ Arthritis (please specify) _____
☐ Cancer (Please specify) _____
☐ Diabetes (Please specify) _____
☐ Epilepsy (please specify) _____

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. ☐ Night sweat

General continued:
☐ Worried ☐ Hopeless ☐ Anxious ☐ Nervous ☐ Calm
☐ Confident ☐ Shy ☐ Stressed ☐ Weepy ☐ Frustrated

☐ Alcohol Intake ☐ Yes ☐ No How much? _____
☐ Smoking ☐ Yes ☐ No How much? _____
Caffeine intake? ☐ Yes ☐ No How much? _____
Exercise: ☐ Yes ☐ No How often? _____

TICK ANY SYMPTOMS YOU HAVE HAD IN THE LAST YEAR:

☐ Depression ☐ Anxiety ☐ Panic attacks ☐ Nervousness
☐ Irritability/ Anger ☐ Dizziness ☐ Fatigue/tiredness ☐ Poor sleep
☐ Epilepsy ☐ Insomnia ☐ Headaches ☐ 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/ Toes ☐ Hands/Wrists/Fingers ☐ Hip
☐ Other _____

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

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: _____

Tick Conditions in blood relatives:

☐ Diabetes ☐ Cancer ☐ Heart Disease
☐ Stroke ☐ Kidney Disease

Women:

☐ Heavy periods ☐ Severe period pains ☐ Length of periods _____
☐ Absent periods ☐ Pale or dark blood ☐ Number of days between each period _____
☐ Fertility issues ☐ Bleeding between periods
☐ Menstrual clotting ☐ Irregular periods ☐ PMT
☐ Sore breasts ☐ Thrush ☐ Recurrent BV
☐ Discharge ☐ Number of pregnancies_____ ☐ Could you be pregnant? ☐ Yes ☐ No
☐ Menopause ☐ Peri menopause ☐ Are you currently breast-feeding? ☐ Yes ☐ No
☐ What age do you reach the menopause? _____

Associated symptoms for menopausal or peri-menopausal women.

☐ Hot flushes ☐ Night-sweats ☐ Forgetfulness
☐ Anxiety ☐ Insomnia ☐ Irregular bleeding
☐ Dry vagina ☐ Reduced libido
☐ Other: _____

Men:

☐ Erectile Dysfunction ☐ Lowered libido ☐ Low Sperm Count
☐ Fertility issues ☐ Prostate trouble. Please specify. _____
☐ 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; please tick the appropriate one/s or add others.

☐ Balanced ☐ Erratic ☐ Unpredictable ☐ Other: _____

☐ Regular emotional states: e.g. ☐ Happy ☐ Sad ☐ Content ☐ Fearful

Is there anything else you would like to discuss or any other health issue that has not been covered?

_____

_____

_____

_____

SIGNATURE & CONSENT

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 understand that no form of anaesthetic will be used in the procedure.

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.

I am aware of the following: -
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.

I have been told about the risks and benefits of acupuncture plus other procedures, and I 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 with Full Circle Health.

All my information will be kept confidential.

I will follow the verbal and written aftercare instructions which have been given to me.
I consent to be contacted via email by Full Circle Health.

_____ _____

The patient (or patient's representative) Signed: Date:

_____

Name:

_____ _____

Acupuncturist. Signed Date:

_____

Name: