Patient Intake form

Overview of patient health - past and present.

* Required

1. **Email address** *

Completing this form.

Please fill in the following form to save time on your first appointment and allow more time for treatment .
Please make sure you answer all questions which have a red star. You will not be able to proceed along the form otherwise.
The information provided will only be used by me.The information will be protected by two step verification password security.

Alternatively, you can download the PDF version on the left to print out and fill in (just click the download button). Please make sure you do not forget to bring it on your FIRST appointment.
Thank you very much!

2. **Date Form Completed** *

Example: December 15, 2012

Your Details

3. **Title** *

Mark only one oval.

- Mr
- Mrs
- Miss
- Ms
- Other:

4. **Full name** *

5. **Address** *

6. **Phone number** *

7. **Date of birth** *

   Example: December 15, 2012

8. **Occupation**

Emergency Information

9. **GP surgery you are registered at** *

10. **Name of emergency contact** *

11. **Phone number of emergency contact** *

Essential information

12. **Are you pregnant or trying to conceive** *

    Mark only one oval.

    - ◯ Yes
    - ◯ No

13. **Do you have lymphoedema or cellulitis** *

    Mark only one oval.

    - ◯ yes
    - ◯ No

14. **Do you regularly take blood thinning medication?** *

Mark only one oval.

- ◯ Yes
- ◯ No

15. **Do you have a pacemaker fitted?** *

Mark only one oval.

- ◯ Yes
- ◯ No

16. **Are you generally warmer or colder than people around you?** *

_____

17. **Have you had acupuncture before** *

Mark only one oval.

- ◯ Yes
- ◯ No

18. **If you had acupuncture before please tell us when, where and why**

_____

_____

_____

_____

_____

19. **What would you like acupuncture to help with? Please state most pressing issue first.** *

_____

_____

_____

_____

_____

20. **Height (approx.)** *

_____

21. **Weight (approx.)** *

_____

22. **Do you smoke?** *

23. **How much alcohol do you tend to drink each week?** *

24. **Do you use recreational drugs? (which and how much per week)** *

    Please remember this form is entirely confidential.

25. **Please tell us which medications you are taking. Please include all supplements and self-medicated items.** *

26. **Do you exercise? Please let us know about any activity which raises your heart rate.** *

27. **What do you like to do in your spare time?**

28. **Please state any serious injuries, accidents , or major surgery, including dates.** *

29. **Please describe what you usually eat daily (including times of eating, i.e. breakfast lunch, dinner, snack)** *

30. **What is your general intake of fluids per day?** *

31. **How many caffeinated drinks (coffee, tea, energy drinks) do you drink each day? Please state.** *

Past and present conditions

32. **Q1.Please tick all conditions you have now, or have had in the past** *

Check all that apply.

- [ ] Angina
- [ ] Asthma
- [ ] Diabetes
- [ ] Epilepsy or seizures
- [ ] Panic attacks
- [ ] Allergies
- [ ] Arthritis
- [ ] Anaemia
- [ ] Dementia /Alzheimer's
- [ ] Hyperthyroid/Hypothyroid
- [ ] Stroke
- [ ] Cancer
- [ ] Heart disease or heart attack
- [ ] Kidney disease
- [ ] Other
- [ ] None of the above

33. **Q1.If you have ticked any conditions above, please give details here**

_____

_____

_____

_____

_____

34. **Q2.Musculo-Skeletal: Please tick all symptoms you have, or have had in the past** *

Check all that apply.

- [ ] Pain or other problems in upper back
- [ ] Pain or other problems in lower back
- [ ] Pain or other problems in neck
- [ ] Pain or other problems in hips or legs
- [ ] Pain or other problems in shoulders or arms
- [ ] Pain or other problems in feet or ankles
- [ ] Pain or other problems in hands and wrists
- [ ] Pain or other problems in fingers and toes
- [ ] Other
- [ ] None of the above

35. **Q2.If you have ticked any symptoms above, please give details here**

36. **Q3.Sleep: Please tick all symptoms you have, or have had in the past.** *
Check all that apply.

- [ ] Difficulty falling asleep
- [ ] Waking in the night
- [ ] Night sweats
- [ ] Sleep disturbed by dreams
- [ ] Waking unrefreshed by sleep
- [ ] Other
- [ ] None of the above

37. **Q3.If you have ticked any symptoms above, please give details here**

38. **Q4.Respiratory: Please tick all symptoms you have, or have had in the past.** *
Check all that apply.

- [ ] Wheezing
- [ ] Breathing difficulties
- [ ] Frequent colds
- [ ] Persistent coughs
- [ ] Sinus problems
- [ ] Hay fever/ rhinitis
- [ ] Nose bleeds
- [ ] Other
- [ ] None of the above

39. **Q4.If you have ticked any symptoms above, please give details here**

40. **Q5.Ears/Eyes: Please tick all symptoms you have, or have had in the past.** *
Check all that apply.

- [ ] Earache
- [ ] Ringing in ears
- [ ] Failing hearing
- [ ] Blurred/ double vision
- [ ] Floaters
- [ ] Dry/watery/sore eyes
- [ ] Other
- [ ] None of the above

41. **Q5.If you have ticked any symptoms above, please give details here**

42. **Q6.Skin/Hair: Please tick all symptoms you have or have had in the past** *
Check all that apply.

- [ ] Dramatic hair loss
- [ ] Bruising easily
- [ ] Dry/ Oily skin
- [ ] Eczema
- [ ] Dermatitis
- [ ] Itching/rash
- [ ] Other
- [ ] None of the above

43. **Q6.If you have ticked any symptoms above, please give details here**

44. **Q7.Urinary: Please tick all the symptoms you have or have had in the past** *
Check all that apply.

- [ ] Urinary tract Infection (UTI)
- [ ] Blood in urine
- [ ] Cloudy or frothy urine
- [ ] Frequent urination
- [ ] Night time urination
- [ ] Urgent urination
- [ ] Kidney infection/stones
- [ ] Pain on urination
- [ ] Other
- [ ] None of the above

45. **Q7.If you have ticked any symptoms above, please give details here**

46. **Q8.Cardiovascular: Please tick all symptoms you have or have had in the past** *
Check all that apply.

- [ ] Chest pain
- [ ] Poor circulation
- [ ] Rapid/ strong heart beat
- [ ] Irregular heart beat
- [ ] Ankle swelling
- [ ] Other
- [ ] None of the above

47. **Q8.If you have ticked any symptoms above, please give details here**

48. **Q9.Digestive/ bowels: Please tick all symptoms you have or have had in the past** *
Check all that apply.

- [ ] Belching/gas/bloating
- [ ] Acid reflux
- [ ] Constipation
- [ ] Diarrhoea/ loose stools
- [ ] Haemorrhoids (piles)
- [ ] Pain in stomach or abdomen
- [ ] Poor appetite
- [ ] Indigestion
- [ ] Nausea/vomiting
- [ ] Other
- [ ] None of the above

49. **Q9.If you have ticked any symptoms above, please give details here**

50. **Gender (biological sex)** *
This will enable me to direct you to the next appropriate section.
Mark only one oval.

- ◯ I am male *Skip to question 57.*
- ◯ I am female

Women

51. **Q10.Menstruation: Please tick all symptoms you have or have had in the past. PLEASE NOTE: if you are post-menopausal refer to your symptoms before the menopause** *

Check all that apply.

- [ ] PMS symtoms
- [ ] Heavy bleeding
- [ ] Light (scanty) bleeding
- [ ] Irregular cycle
- [ ] Clots in blood
- [ ] Other
- [ ] None of the above

52. **Q10.If you have ticked any symptoms above, please give details here**

_____

_____

_____

_____

_____

53. **Q11.Please tick all symptoms you have or have had in the past** *

Check all that apply.

- [ ] Trush or other vaginal infections
- [ ] Loss of libido
- [ ] Vaginal dryness
- [ ] Pelvic pain/vulvodynia
- [ ] Other
- [ ] None of the above

54. **Q11.If you ticked any of the above symptoms, please give details below:**

_____

_____

_____

_____

_____

55. **Menopause: If you are peri-menopausal, or menopausal, please outline any symptoms here(such as hot flushes. anxiety, sleep problems, weight gain, etc)** *

56. **Number of pregnancies, number of children, age of children** *
For example (3 pregnancies / 3 children / ages 15, 13, 11)

57. **Current contraceptive method** *

Skip to question 59.

Men

58. **Q12.Please tick all the symptoms you have now or have had in the past** *
Check all that apply.

- [ ] Erection difficulties
- [ ] Prostate problems
- [ ] Other
- [ ] None of the above

59. **Q12.If you have ticked any symptoms above, please give details here**

Skip to question 59.

Male or female:

60. **Is there anything else you might want to tell us, that might be relevant to your health?** *
If there is nothing further please enter - NONE

61. **Do you need a ramp to enter the clinic?** *
Mark only one oval.

- No
- Yes

Confirmation

62. **Giving blood** *
If you are regularly giving blood, we need to inform you that you won't be allowed to give blood for 4 months after the date of your last acupuncture treatment.
Check all that apply.

- [ ] Please tick this box to acknowledge this.

63. **Confirmation of information** *
Please tick the box to confirm that you have given us all relevant information about your health in your answers above; that you have not omitted anything; and that you're happy to be treated with acupuncture on the basis of the information you've given
Check all that apply.

- [ ] I confirm the above.

Thank you for taking the time to complete this Patient Intake Form

Click SUBMIT to finish

- [ ] Send me a copy of my responses.

Powered by
Google Forms