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| Office Use | | | | | |
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**MEDICAL QUESTIONAIRE**

Please complete the following details. This information is used solely for clinic data and treatment purposes. All information provided is strictly confidential.

| How do we contact you? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Title |  | | | | | | | | | | | | Mobile No. | | | | | | | |  | | | | | | | | | | | | |
| Surname |  | | | | | | | | | | | | Landline No. | | | | | | | |  | | | | | | | | | | | | |
| Forenames |  | | | | | | | | | | | | Next of Kin | | | | | | | |  | | | | | | | | | | | | |
| Sex |  | | | | | | | | | | | | Mobile No. | | | | | | | |  | | | | | | | | | | | | |
| Date of Birth |  | | | | | | | | | | | | Family doctor | | | | | | | |  | | | | | | | | | | | | |
| Occupation |  | | | | | | | | | | | | Address | | | | | | | |  | | | | | | | | | | | | |
| Address |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | |
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| Postcode |  | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | |
| Email | a | l | e | x | a | n | d | e | r | f | l | e | | | m | i | n | g | @ | h | | o | t | m | a | i | l | , | c | o | . | u | k |
| Do you consent to being included on our mailing list? | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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| Have you tried acupuncture or Chinese herbal medicine before? If so, please provide details: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **How can we help?** | |
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| To what extent does this problem affect your daily activities (work, sleep, eating etc)? |  |
| When did you first notice any symptoms? |  |
| Have you been given a diagnosis by your GP?  If so, what is your diagnosis? |  |
| What kinds of treatment or therapy have you tried? |  |

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| **COVID-19 Safety Precautions** |
| Your health and safety is our first priority so we ask you to read and comply with our posted safety precautions, and confirm the following;   * I have not had a fever in the last five days, a persistent dry cough, or recent loss of taste or smell * I have not been in contact within anyone presenting COVID-19 like symptoms in the past 14 days * I have not been told to shield or self-isolate currently.   In the eventuality that I (the practitioner) get symptoms of COVID-19 within 48 hours of having close contact with you during the appointment and then later test positive, I am obligated under law to provide your name, phone number or email and the date and time of your visit to the test and trace service. Please note that by attending the appointment you give consent for this. |

**\*\*PLEASE COMPLETE OVERLEAF\*\***

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| **A little more about you?** (Please include dates) | | | | | | | | |
| **Have you any history of?**  □ Allergies (please provide details below)  □ Cancer  □ Diabetes  □ Hepatitis  □ High blood pressure  □ Heart disease  □ Seizures  □ Sickle Cell  □ Rheumatoid Arthritis  □ Connective Tissue Disorders  □ Celiac Disease  □ Rheumatic fever  □ Surgery  □ Venereal disease  □ Thyroid disease  □ Birth trauma (prolonged labour, forceps delivery etc)  □ Other significant illness (describe) | | | | | Other relevant medical history (Allergies, Surgery etc.) | | | |
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| Current Medications (Please list) | | | |
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| Accidents or significant trauma (Please describe) | | | |
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| **Please mark any symptoms you experience as (times) per day, (W)Weekly, (M)Monthly or (Y)Yearly** | | | | | | | | | |
|  | | Painful joints |  | Food craving |  | | Psoriasis |  | Red/ Itchy/ watery eyes |
|  | | Aching muscles |  | Hyperactivity |  | | Acne |  | Itchy/ tingling lips/mouth |
|  | | Arthritis |  | Insomnia |  | | Red, itchy spots |  | Mouth ulcers |
|  | | Fatigue/tiredness |  | Stomach cramps |  | | Rashes |  | Runny nose |
|  | | Swollen lips |  | Migraines |  | | Hives/urticaria |  | Sinusitis |
|  | | Swollen tongue |  | Headaches |  | | Excess gas |  | Sneezing |
|  | | Swollen throat |  | Palpitations |  | | Abdominal bloating |  | Blocked nose |
|  | | Swollen face |  | Panic attacks |  | | Constipation |  | Wheezing |
|  | | Anxiety/Stress |  | Excessive dry skin |  | | Diarrhoea |  | Hay fever(Pollen allergy) |
|  | | Mood swings |  | Itchy skin |  | | Acid reflux/heartburn |  | Asthma |
|  | | Depression |  | Redness |  | | Indigestion |  | Coughing |
|  | | Dizziness |  | Burning feeling skin |  | | IBS |  | Shortness of breath |
|  | | Foggy head |  | Eczema/dermatitis |  | | Vomiting or nausea |  |  |

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| **How did you hear about Acu-Synergy Clinic?** | |
| □ Internet search  □ Brochure  □ Recommendation by existing patient | □ Referral by Medical Practitioner  Name/Practice……………………………………………… |

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| **Privacy Policy** |
| The data we collect is for the purposes of your treatment and for communication directly with you for treatment or booking purposes. We do not share your data with 3rd parties unless legally obliged, and do not use your data for marketing purposes except as authorised above. You are free to ask at any time for all data to be destroyed or dealt with however you wish. |

By signing I am confirming the accuracy of my medical declaration and accepting Acu-Synergy privacy policy, terms of service and billing terms.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_