HOOLE ACUPUNCTURE CLINIC

78-76 Faulkner Street, Hoole, Chester, CH23BE

ACUPUNCTURE QUESTIONNAIRE AND CONSENT FORM

PATIENT DETAILS

Name _____ **Date of Birth** _____

Address _____

_____ **Telephone** _____

PATIENT MEDICAL HISTORY

Do you (Does the patient, if completing for an under-16) currently suffer from, or have you (they) ever suffered from any of the following?

	YES	NO	DETAILS
Heart condition/angina			
Blood pressure problems			
Epilepsy/seizures			
Haemophilia/blood clotting disorders			
Blood borne virus, e.g. Hepatitis B/C or HIV			
Skin complaints, e.g. psoriasis, eczema			
Diabetes			
Allergic response, e.g. anaesthetics, jewellery			
Do you regularly take any blood-thinning medication? e.g. aspirin?			
Covid19?			
Do you take any regularly prescribed medication?			
Could you be pregnant?*			
*Have you consulted your midwife on acupuncture?			

I declare that the information I have provided on medical history is correct to the best of my knowledge and hereby give consent for acupuncture to be carried out by the practitioner. I confirm that I have been informed of potential complications that are sometimes associated with the procedure and appropriate aftercare that may be required. I give consent to the practitioner to retain the details provided on this form for a period of 7 years from today. The details will not be shared with a 3rd party without your consent.

General Data Protection Regulation (GDPR) Consent:

As clinic customer we may occasionally send you texts or emails to inform you about your treatments or appointment booking changes or important changes to our services that may affect you. To continue to provide you with important updates on your treatments and booking times we request your consent / opt-in to stay in touch with you. We will never provide your details to a 3rd party or send you marketing information.

Yes: opt me in ☐

Signature of Patient _____ Date ___/___/_____

Where patient is under 16 years old, details and consent of parent or guardian:

Name _____ **Relationship to Patient** _____

Address _____

Telephone _____ **Proof of ID provided? Y N**

Signature of Parent or Guardian _____ **Date** ___/___/____

Signature of Practitioner _____ **Date** ___/___/____