Integrated Health Clinic

CLIENT NO:

PATIENT QUESTIONNAIRE

REGISTRATION DATE:……

TITLE: …… FIRST NAME …….. SURNAME: ……..

DOB:…… AGE: …….. MARITAL STATUS:…….. NO. OF CHILDREN: ……..

ADDRESS: ……

…… POST CODE: ……

EMAIL:…… MOBILE NO: ……

OCCUPATION: …….. EMERGENCY CONTACT NO:……

GP SURGERY: ……..

If applicable, are you pregnant, or aiming to become pregnant ? ☐Yes ☐No

Do you have any implants e.g. pacemaker, hip replacement? ☐ Yes ☐No ……..

1. Please list the problem you want help, and how long you have had it

……

……

……

……

……

2. List any other diagnosis, illnesses and operations.

……

……

……

.3. Medications, Herbs & Supplements.

1. …….. 5. ……..

2 …….. 6 …….. .

3 …….. 7. ……..

4 …….. 8. ……..

3. List any Family illnesss or diagnosis.

……

……

4. Allergy & Other

Do you have a bleeding disorder ? ☐Yes ☐No ……

Do you have any allergies ? ☐ Yes ☐No ……

Do you react to any foods or chemicals ? ☐Yes ☐No ……

Do you smoke or vape ? *(how many a day)* ☐Yes ☐No ……

CREATED: 13/6/2025

Do you drink alcohol ? *(how much per wk)* ☐ Yes ☐ No ……

Do you use recreational drugs ? ☐ Yes ☐ No ……

5. General Health *(tick all that apply to you)*

General /Mood/Emotion ☐ Tiredness/Fatigue ☐ Anxiety/Depression ☐ Anger/irritability ☐ Feel stressed ☐ Sleep problems **Genitourinary System** ☐ Problems passing urine ☐ Wake, to go to toilet at night	**Digestion** ☐Bloating/Heartburn ☐Abdominal pain ☐Diarrhoea ☐Constipation **Central Nervous System** ☐ Headaches ☐ Loss of power in arm or leg ☐ Pins & needles in arm or leg	**Respiratory** ☐ Cough ☐ Shortness of breath **Gynaecological** ☐ Period pain (mild/moderate/severe) ☐ PMT …… **Skin** ☐ Dry skin, hair, sensitivity ☐ Rashes/ itching

6. Additional information

……

……

……

……

……

8. Data Protection

I explicitly consent you to create and store medical records concerning my treatment, including details of my medication, treatment and any other relevant issues in accordance with the ***General Data Protection Regulation (GDPR).*** *As per your 2025 Privacy Policy which I have seen, I understand records will be retained for as long as I am receiving services. After which, it may be kept for up to 5 years, or longer if deemed necessary by the Integrated Health Clinic to comply with professional guidelines.*

9. Informed Consent

I hereby request and consent to the performance of acupuncture, massage and other associated procedures on me. I am fully aware that I am participating in these sessions at my own risk, and accept that there may be unintended treatment side effects. I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites; dizziness or fainting. Burns and/or scarring with moxibustion, cupping or the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

My preferred communication route/s is: ☐ Telephone ☐ Text ☐ Email ☐ Other……

I confirm that all information included on this questionnaire is correct to the best of my knowledge.

Signature …… **Date** ……

Patient name: ……

If acting as a legal guardian, please state your role and authority: ……