

## Questionnaire and Consent Form

### Client Details

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Mobile No. \_\_\_\_\_ Email \_\_\_\_\_

I consent to clinic updates/marketing being sent to my email address by TCM Practice   
 Referred by \_\_\_\_\_ (e.g. friend, GP, advert, website)

### GP Details

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

### Client Medical History

Do you currently suffer from, or have you ever suffered from any of the following?

	Yes	No	Details
Heart conditions/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 medicines, e.g. aspirin?			
Do you take any regular prescribed medicines?			
Do you take any regular supplements or herbs?			
Do you have any implants?			
Could you be pregnant?			
Details of any associated problems with treatment			

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 TCM Practice practitioners. I confirm that I have been provided with written information on the potential complications associated with the procedure, aftercare advice and the privacy notice location, all contained in the "Information Sheet".

Signature of client \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_