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| **Liz Jeannet Acupuncture**  **White Crane Clinic NW1 8XE & Olney Treatment Rooms MK46 4LA** [**www.lizjeannet.com**](http://www.lizjeannet.com)[**liz@lizjeannet.com**](mailto:liz@lizjeannet.com) **07764 604998**  **Registration Form – Private & Confidential** |

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| **Patient Details** | | | | |
| Name | GP’s Name | | | |
| Address | GP’s Address | | | |
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| Postcode | GP’s Phone No | | | |
| Home Phone No | If we need to contact your doctor do you prefer this to be | | | |
| Work Phone No | your GP or specialist – give details if not as above | | | |
| Mobile Phone No |  | | | |
| email |  | | | |
| Date of birth: |  | | | |
| Occupation: | Are you receiving any other therapies – give details | | | |
| How did you hear about us? |  | | | |
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| **Reason for your visit** | | | | |
| 1. Presenting Condition | | Duration | | |
| 2. Presenting Condition | | Duration | | |
| 3. Presenting Condition | | Duration | | |

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| **Medical History** | |
| Date | (please include illness/surgery/accidents/hospital admissions/seizures/fainting/bleeding disorders) |
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| Investigations in last 3 years | |
| Blood tests | When and why did you last see your doctor |
| X-rays |  |
| Ultrasound |  |
| MRI |  |
| Other – give details |  |
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| Family health history | |
|  | Illness and age of onset |
| Mother |  |
| Mother’s parents |  |
| Father |  |
| Father’s parents |  |
| Siblings |  |
| Are there any disease traits (e.g. arthritis, cancer, heart disease, epilepsy, diabetes) in your family? | |
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| General | |
| Weight | Alcohol |
| Height | Tobacco |
| Allergies | Recreational drugs |
| For women, date of last menstrual period | Do you have a pacemaker or other electrical implant |
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| Pain and Symptom Map | |
|  | Please mark areas of   * Pain * Numbness * Tingling * Pins and needles * Other symptoms – give details |

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| **Symptom checklist – please tick if you’ve had in last 3 months** | |
| Pain | Headaches |
| Fatigue | Shortness of breath |
| Weight loss/gain | Palpitations |
| Anxiety/depression | Cough |
| Sleep difficulties | Digestive problems |
| Fevers/night sweats | Nausea or vomiting |
| Swollen glands | Diarrhoea or constipation |
| Visual problems | Urinary tract symptoms |
| Hearing difficulties | Skin rashes |
| Bleeding gums, Mouth ulcers | Lumps or unexplained bleeding |

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| **Medication - please give name and dosage** | |
| Prescription medication | Over-the-counter medication & supplements |
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| What is your priority in terms of treatment today? |
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