|  |
| --- |
| **Liz Jeannet Acupuncture @ The Olney Treatment Rooms**  **Osborns Court, Olney, MK46 4LA.** [**www.olneytreatmentrooms.com**](http://www.olneytreatmentrooms.com)[**www.lizjeannet.com**](http://www.lizjeannet.com) **07764 604998**  **Registration Form – Private & Confidential** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Details** | | | | |
| Name | GP’s Name | | | |
| Address | GP’s Address | | | |
|  |  | | | |
|  |  | | | |
| 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? |  | | | |
|  |  | | | |
|  |  | |  |
| **Reason for your visit** | | | | |
| 1. Presenting Condition | | Duration | | |
| 2. Presenting Condition | | Duration | | |
| 3. Presenting Condition | | Duration | | |

|  |  |
| --- | --- |
| **Medical History** | |
| Date | (please include illness/surgery/accidents/hospital admissions/seizures/fainting/bleeding disorders) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| Investigations in last 3 years | |
| Blood tests | When and why did you last see your doctor |
| X-rays |  |
| Ultrasound |  |
| MRI |  |
| Other – give details |  |
|  |  |

|  |  |
| --- | --- |
| 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? | |
|  | |

|  |  |
| --- | --- |
| General | |
| Weight | Alcohol |
| Height | Tobacco |
| Allergies | Recreational drugs |
| For women, date of last menstrual period | Do you have a pacemaker or other electrical implant |
|  |  |

|  |  |
| --- | --- |
| Pain and Symptom Map | |
|  | Please mark areas of   * Pain * Numbness * Tingling * Pins and needles * Other symptoms – give details |

|  |  |
| --- | --- |
| **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 |

|  |  |
| --- | --- |
| **Medication - please give name and dosage** | |
| Prescription medication | Over-the-counter medication & supplements |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| What is your priority in terms of treatment today? |
|  |
|  |
|  |
|  |
|  |