British Acupuncture Council Member

professional standards authority accredited register

Acupuncture questionnaire and consent form

Name | | Date of birth | | | | | | | |

Contact details

Address		Home tel.	
		Mobile tel.	
		Work tel.	
		email	

Practitioner's name: Eleanor Henderson BAcC mem no. 9 5 9 7 0 2

Medical information

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

	Y	N	
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 medicines, e.g. aspirin?			
Do you take any regularly prescribed medication?			
Details of any associated problems with treatment			

Declaration

I declare that the information I have provided on medical history is correct to the best of my knowledge & hereby give consent for acupuncture/functional medicine lab work to be carried out by the named practitioner.

I confirm that I have been provided with written information on

(i) the potential complications associated with the procedure and

(ii) appropriate aftercare advice for acupuncture. I understand that the practitioner is required to keep patient records for a period of 7 years from the date of the last treatment.

I confirm that I have read & understood the Terms & Conditions outlined in www.acupuncturesoutheast.co.uk/faq-s especially regarding the 24 hr cancellation policy.

Signature of patient ____________________ Date | | | | | | | | |

Signature of practitioner ____________________ Date | | | | | | | | |

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