Acupuncture South East

PREGNANCY CONSULTATION FORM

Date______________________

Name______________________

Address______________________

____

Date of Birth______________ **Age**__________

Registered GP surgery______________________

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Occupation______________________

Phone______________________

Email______________________

Another person we may contact if needed:

Name______________________

Phone______________________

How many weeks pregnant & Due date?______________

____

Previous miscarriages?______________________

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No. of children with date(s) of birth______________

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____

Preferred birth plan? ______________________

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Any Complications in Previous Pregnancies?__________

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How did you hear about us______________________

What are your treatment goals?______________________

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Medical history: (major injuries, accidents, operations, childhood illnesses, allergies etc)______________

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Current medication:______________________

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____

TESTS HAD/BOOKED (circle & date)

Ultra Sounds (prior to 12 week scan)______________________

Neuchal Scan (12 week scan)______________________

Amniocentesis______________________

Chorionic Villus Sample (CVS)______________________

Other______________________

HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS?	BEFORE PREGNANCY?	DURING PREGNANCY?
Cardiovascular Disease, Stroke, Thrombosis, Embolism, Heart Attack or Angina		
Cancer		
Diabetes		
Epilepsy		
High or Low Blood Pressure		
Lupus		
Multiple Sclerosis		
Rheumatoid Arthritis		

HAVE YOU EXPERIENCED ANY OF THESE SYMPTOMS ***IN THIS*** PREGNANCY?	
Back Ache	Headaches
Bleeding	Indigestion/Heartburn
Breathlessness	Ligament Pain
Carpal Tunnel	Nausea
Constipation	Sciatica
Cramps	Pubis Symphysis Dysfunction
Dizziness	Twitchy/Restless Legs
Fluid Retention	Varicose Veins
Haemorrhoids	Other

I confirm that the above details, to my knowledge are accurate & that I consent to having pregnancy massage/acupuncture.

Signature:____

Print:______________________________ **Date:**______________________________