Main Consultation Form

All details are kept strictly confidential in compliance with GDPR.

Name:		
Address:		
City:		Postcode:
Phone:		
Email:		
Date of Birth:	Gender:	Biological sex: M / F
Occupation/Hobbies:		

Known medical conditions:		**Current medication:**
○ Back pain	○ Fertility problems	
○ Breathing problems	○ Hypertension	
○ Cancer	○ Immune condition	
○ Cardiac disease	○ Musculoskeletal pain	
○ Chronic fatigue/ME	○ Neurological conditions	
○ Depression/mood disorders	○ Skin conditions	
○ Diabetes	○ Thyroid disease	
○ Digestive complaints	○ Other	

Weekly units of alcohol:	Number of cigarettes a day:
Non-prescription drugs:	How often?
Hours of exercise a week:	Forms of exercise:

Main concern: please describe	
What triggered this?	
When did it start?	Have you had this before?
How does it limit you?	
What other problems does it cause?	
How has it changed with time?	

What treatments have you had?	
Better or Worse: How do these change it ?	
○ The weather or temperature ○ Times of day ○ Pressure or massage	○ Stress ○ Diet choices /eating ○ Movement

Please list any other health issues:

Appetite

Do you have a healthy appetite?	Has appetite been an issue?
Do you follow a particular diet?	Do you have food allergies/intolerances?

Do you get:

○ Nauseous ○ Bloating under the ribs ○ Bloating in the lower abdomen ○ Heartburn or reflux ○ Bleeding gums ○ Cravings for certain foods	○ Mouth ulcers/soreness ○ Bad breath ○ Hiccoughs ○ Pain under the ribs ○ Pain in the lower abdomen ○ Tight chestedness or pain
Thirst: do you tend to: ○ Sip drinks ○ Gulp drinks	○ Prefer hot drinks ○ Prefer cold drinks ○ Drink in the night
Sleep: Hours sleep (usually): ○ Sleep well ○ Wake in the night ○ Get to sleep at:	○ Feel rested on waking ○ Feel heavy on waking ○ Have nightmares or sleepwalk ○ Take sleeping meds

Energy:

How's your energy?	(Low) 1----2----3----4----5----6----7----8----9----10 (High)				
If you get tired, is it mainly:	(a) your trunk	(b) your limbs	(c) your head	(d) everywhere	
Do your limbs feel:	(a) strong & vital	(b) weak	(c) heavy		
Are you energised by: ○ Resting ○ Exercising ○ Socialising ○ Eating			Are you more tired/groggy after: ○ Resting ○ Exercising ○ Socialising ○ Eating		

Lungs: have you experienced?

○ Asthma ○ Wheezing ○ Recurrent tonsilitis ○ Hayfever/allergies ○ Sinusitis/Glue ear	○ Bronchitis ○ Pneumonia ○ Chronic cough ○ Breathlessness ○ Other chest problems

Do you get? (please use the 'Pain/Skin Form' if skin is significant)

○ Dizzy on standing ○ Dizzy at other times ○ Easily startled ○ Palpitations on exercise ○ Palpitations at night ○ Dry hair or nails	○ Eczema or dry skin ○ Acne or spots ○ Itchy skin ○ Oily skin ○ Rashes ○ Other skin conditions

Temperature/sweating: do you feel?

○ Hot at night ○ Cold at night ○ Alternating heat and coldness ○ Generally feel more hot or cold	○ Night sweats ○ Excessive sweating – when? ○ Sweat in specific areas of the body – where? ○ Temperature shifts in the afternoon

Mood scales (optional)

How's your mood generally	(Low) 1----2----3----4----5----6----7----8----9----10 (High)	
How are your anxiety levels?	(Low) 1----2----3----4----5----6----7----8----9----10 (High)	
How restless are you?	(Very) 1----2----3----4----5----6----7----8----9----10 (Not very)	
How are your irritability levels?	(Low) 1----2----3----4----5----6----7----8----9----10 (High)	
How easy is it to engage in tasks?	(Easy) 1----2----3----4----5----6----7----8----9----10 (Difficult)	
How's your memory?	(Good) 1----2----3----4----5----6----7----8----9----10 (Worrying)	

Head: do you get?

○ Headaches or migraines ○ Sharp pain ○ Dull pain or woolly-headedness ○ Pain at the forehead ○ Pain on the back or sides of the head ○ Poor concentration	○ Tired eyes ○ Red or irritated eyes ○ Tinnitus ○ Hearing problems ○ Blurred vision ○ Dry eyes or floaters

Pain (please use the 'Pain/Skin Form' if pain is significant)

What's uncomfortable? (Does it feel…sharp, tight, numb, dull, achy, burning, heavy?)	
Better for (heat, cold, pressure, moving, rest)?	Worse for?
Do you get lower backache or knee pain?	Stiff shoulders or neck?

Bowels (please use the 'Digestion Form' if your digestion is a concern)

Do your bowels open regularly?	How often do you go a day/week?
Does stress affect your bowel habits?	Do you get associated pain or discomfort?
Do you get: ○ Undigested food in stools ○ Mucus with your stools ○ Blood with your stools ○ Alternating constipation & diarrhoea	Is opening the bowels ○ Easy ○ Difficult or slow ○ Urgent ○ With an incomplete feeling
The Bristol Stool Chart choices: 1. Hard lumps like nuts 2. Sausage-shaped 3. Soft blobs to watery	Colour ○ Yellow or pale ○ Brown ○ Black or like coffee grounds
Intestinal Wind ○ Very little ○ Too much	○ Causes discomfort ○ Little odour ○ Foul-smelling

Bladder:

Urgency	Cloudiness
Infections (UTIs)	Heaviness
Number of visits to the loo at night:	Dribbling/leaking issues

Health History

Historical Challenges: e.g. 2005 – Glandular Fever	
Significant family illnesses	
Steroids in the last 2 years:	Antibiotics in the last 2 years:
Supplements:	

Additional information:

By completing & signing this form, you agree in principle to acupuncture treatment, knowing that you may review and withdraw permission by telling the practitioner.

Signature: Date:

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