Welcome to

Institute of Sports and Spines

Acupuncture New Patient Information Form

Title:_____ Name:_____ Middle Initial/s:____ Surname:_____

Home Address: _____ Suburb: _____ Postcode: _____

D.O.B._____ **Phone:** Home:_____ Work:_____ Mob:_____

*If you are a **current patient** of Institute of Sports and Spines, please skip to **'Reason for Visit' section below.***

E-mail address: _____

Private Health Fund: _____ Memb No. _____ No. on Card ___

Medical Practitioner's (GP) Name: _____ Phone: _____

Next of Kin/Emergency Contact:_____ Relationship: _____ Ph: _____

Name of person who referred you to us or how did you hear about us?_____

What is your occupation or major daily activity? _____

Hobbies / Sports / Specific Health interests: _____

Do you exercise regularly? If so please give details: _____

I would like to receive marketing emails from Institute of Sports and Spines ☐ Yes ☐ No

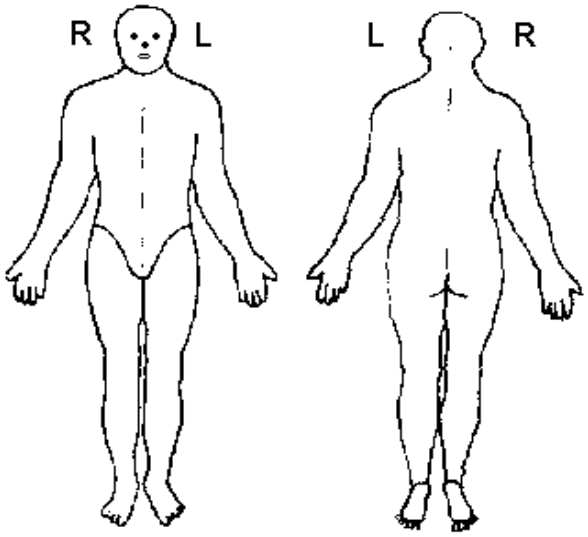
REASON FOR VISIT: _____

Musculoskeletal Condition: □ Yes □ No (go to page 2)

Please indicate the approximate areas on the diagrams:

Pain - XXXX Pins & Needles - \\\\\\\\\\

Numbness - 000000



Please indicate the level of pain you are suffering.

0_____**10**

How would you describe the pain/problem?

_____

_____

When and how did the problem start?

_____

Does it re-occur? ☐ Yes ☐ No When and how often?_____

Is the pain worse: ☐ Morning ☐ Evening ☐ During the night Does the pain wake you at night? ☐ Yes ☐ No

Does anything aggravate the pain? ☐ Lying ☐ Standing ☐ Sitting ☐ Movement ☐ Other _____

Does anything relieve the condition? ☐ Yes ☐ No If yes please explain_____

Have you taken any form of pain killer prior to this treatment? _____

What treatment have you had for this condition? _____

What goals do you hope to achieve with treatment? _____

Are you good at maintaining exercises and routines or do you need support? _____

What activities cause you pain? What do you avoid because of the potential for pain or restriction? What would be good benchmarks to use to assess progress?_____

Please fill in page 2-

Please indicate by ticking the box if you experience symptoms in any of the following areas:

HEADACHES:
frequency - _____
☐dull ache
☐sharp pain

RESPIRATORY:
☐cough
☐wheezing
☐shortness of breath
☐phlegm/mucous
☐sinusitis

SKIN:
☐acne/pimples
☐rashes
☐itchiness
☐dry skin

DIGESTION:
☐abdominal pain
☐abdominal bloating
☐nausea/vomiting
☐diarrhoea
☐constipation
☐regurgitation
☐appetite

SLEEP:
☐difficulty falling asleep
☐waking during the night
☐difficulty sleeping due to pain
☐sleeping too much
☐restless legs

MUSCULAR/SKELETAL:
☐muscular aches/cramps
☐neck & shoulder tension
☐joint pain
☐back ache

URINARY
☐clear, copious
☐frequent
☐night-time urination
☐burning
☐scanty/ dark
☐stops mid-flow

MENSES:
☐cramps / pain
☐no. of days _____
☐heavy/light flow
☐colour _____
☐regular cycle ____days

ARE YOU PREGNANT?
☐ Yes ☐ No
no. of children _____
☐miscarriages

OTHER:
☐fatigue
☐dizziness
☐oedema
☐bruise easily
☐varicose veins
☐ringing in ears
☐poor memory
☐sore or dry eyes
☐allergies/sensitivities
☐frequent infections
☐emotional state
☐thirst

SWEATS/TEMPERATURE:
☐sweating with little exertion
☐aversion to cold &/or cold weather
☐aversion to heat &/or hot weather
☐night sweats
☐hot flushes

Pleases complete the following details

Current prescription medications:
Current vitamins/minerals/supplements/herbs:
Diet (breakfast, lunch, dinner, snacks, drinks):
Lifestyle (exercise, smoking, drugs):

Please indicate if you have or have ever had any of the following

Diabetes:	Yes/No
Cancer:	Yes/No
Do you faint easily?	Yes/No
Do you have a pacemaker?	Yes/No
Do you have any joint replacements?	Yes/No
Do you have any conditions that might compromise your immunity?	Yes/No

Please fill in page 3-

This practice may use any of the following therapies:

Acupuncture
#Massage
#Dermal Hammer
#Cupping
#Moxabustion
#Chinese herbal medicine
#Electro Acupuncture

Consent To Treatment – Patient Information

The therapies offered at the clinic have a long history of safe practice, however there are always risks associated with any sort of treatment. Below is a list of potential risks associated with the therapies offered at the clinic. We will explain all treatments before we commence them but you may ask if you require further explanation or have specific questions. Please tell your practitioner if you do not want any particular type of therapy.
Please initial next to each paragraph when you have read it.

Outline of possible risk	**Therapy**	**Your initial**	**Strategies to minimize possible risk**
Pain	Acupuncture Massage Cupping Dermal hammer		Tell your practitioner if you are sensitive to stimulation and if you become uncomfortable or experience any pain during the treatment
Bruising	Acupuncture Massage Cupping Dermal hammer		Tell us if you bruise easily or have a bleeding disorder. Small bruises are always possible with acupuncture. Cupping typically leaves bruises which are usually painless and can last over a week. It is important to tell us if bruises in the area being treated are cosmetically unacceptable
Infection	Acupuncture Massage Cupping Dermal hammer		**We only use pre-sterilised single-use disposable acupuncture needles in this clinic.** It is possible to develop an infection whenever the skin is punctured so tell us if you have a known immune problem so we can take special precautions. Some medications can affect your skin and immune system so we need to know what medications you are taking
Burn	Moxabustion		Please advise your practitioner if you have sensitive skin. And tell your practitioner if the heat is uncomfortable
Smoke irritation	Moxabustion		Please advise your practitioner if you have any medical conditions affecting your respiratory system such as asthma.
Relaxed sleepy	Acupuncture Massage Cupping Reiki		It is common to feel relaxed or sleepy after treatment so avoid getting up quickly from the treatment table and give yourself time to adjust before using stairs or driving
Fainting	Acupuncture Massage Cupping Dermal hammer		Do not skip a meal before treatment and get up slowly after.
Aggravation	Any therapy		It is possible that your condition could be aggravated .

We value your time and appreciate helping you with your Health care needs. Your appointment is important to us.
As missed appointments may inconvenience other patients, our clinic has employed a policy of charging a normal consultation fee for missed appointments and those appointments cancelled without 4 hours notice. We hope that this does not inconvenience anyone too much and should ensure in future that you have the best opportunity of having your needs met in an appropriate time frame.

Print Full Name:_____ **Patient's Signature(or Legal Guardian):**_____

Date: / / 20____