PATIENT INTAKE FORM
for treatment with Ka Hang Leoungk

Date: _____ Name: _____

Name of Parents/Guardians (if under 18): _____

Address: _____

_____

Date of Birth: _____ Age: _____ Occupation: _____

Telephone: Mobile _____ Home_____

Email: _____

Would you like to receive the Pointspace Newsletter? You can unsubscribe at any time. ___Yes ___No

Emergency contact name & phone number: _____

Name & address of GP: _____

_____

Current medications / dosages: (Include over the counter, supplements, vitamins, herbs)

In order of importance, reasons for seeking treatment:

1.

2.

3.

How did you hear about us? If website, please specify _____

Referred by: _____

Have you had acupuncture before? _____ From whom? _____

Signature: _____ Date: _____

Name _____ **Date** _____

1. Health History: Have you ever been diagnosed with any of the following?

__ Tension headaches
__ Migraine headaches
__ TMJ disorder
__ Back pain or sciatica
__ Chest pain or angina
__ Abdominal pain
__ Pelvic or genital pain
__ Rheumatoid arthritis
__ Osteoarthritis
__ Fibromyalgia
__ Chronic fatigue syndrome
__ Bone fracture/joint sprain
__ Muscle spasm or tremor
__ Carpal tunnel syndrome
__ Tennis elbow
__ Frozen shoulder
__ Peripheral neuropathy
__ Shingles (herpes zoster)

__ Coronary disorder or heart attack
__ Lung or respiratory disorder
__ Liver disease or hepatitis
__ Urinary of bladder infection
__ Kidney disorder of kidney stones
__ Gallbladder disorder or gall stones
__ Spleen or lymphatic disorder
__ Gastric or peptic ulcer
__ Irritable bowel syndrome or colitis
__ Diabetes mellitus
__ Hypoglycaemia
__ Thyroid disorder
__ Dysmenorrhoea (painful menstruation)
__ Pre-menstrual syndrome
__ Prostate or vaginal disorder
__ Skin disorder, eczema, psoriasis
__ Raynaud's disease
__ Deafness or tinnitus

__ High blood pressure
__ Low blood pressure
__ Stroke
__ Seizure or epilepsy
__ Concussion
__ Cancer or tumours
__ HIV+ or AIDS
__ Multiple sclerosis
__ Polio or mononucleosis
__ Allergies or hayfever
__ Asthma or bronchitis
__ Tuberculosis
__ Pneumonia
__ Attention deficit disorder
__ Obsessive-compulsive
__ Panic attacks or phobias
__ Major depression
__ Schizophrenia

2. Accidents: Have you ever been injured in any of the following types of accidents?

__ Automobile accident
__ Athletic injury
__ Work-related accident
__ Surgical complication
__ Accident at home
__ Other accident

3. Current Conditions: In the past year, have you noticeably experienced any of the following?

__ Pain in legs or feet
__ Pain in arms, wrist, hands
__ Cold hands of cold feet
__ Swollen ankles of feet
__ Stiff, aching joints
__ Neck or shoulder tension
__ Grinding your teeth
__ Rapid heart beat
__ Excessive sweating
__ Hyperventilation
__ Dizziness or fainting

__ Large weight gain or weight loss
__ Overeating or binge eating
__ Under eating or poor appetite
__ Craving for sweets of chocolate
__ Craving for drugs or alcohol
__ Dissatisfaction with job
__ Bored or uninterested in things
__ Loneliness or lack of affection
__ Sex life not satisfying
__ Thoughts of killing yourself
__ Worried about finances

__ Sinus congestion
__ Colds, flu or chills
__ Sore throat
__ Nausea or vomiting
__ Diarrhoea
__ Constipation
__ Blurred vision
__ Lethargy, fatigue
__ Difficulty sleeping
__ Disturbing dreams
__ Relationship problems

4. Substances or Medications: In the past several months, did you regularly take any of these?

__ Cigarettes or cigars
__ Several cups of coffee/day
__ Glass or beer or wine
__ Liquor or mixed drinks

__ Aspirin
__ Prescribed pain reliever medication
__ Recreational drugs/marijuana
__ Several cans of soft drink/day

__ Sleeping pills
__ Anti-anxiety pills
__ Anti-depressant pills
__ Blood pressure pills

ACUPUNCTURE INFORMATION and INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me by Ka Hang Leoungk, MBAcC.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion and cupping.

Side effects such as local bruising, broken needles, pain at site of insertion, pneumothorax, spontaneous miscarriage are rare but possible. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify the practitioner if I am or become pregnant. I will notify the practitioner if I have a bleeding or other serious health disorder.**

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

Payment in full is expected at the time of service. **I understand that should I need to cancel an appointment, at least 24 hours notice will be given. I understand that I will be charged the full treatment fee for missed or cancelled appointments with less than 24 hours notice.**

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ADDITIONAL INFORMATION FOR COSMETIC ACUPUNCTURE (please tick after you've read this):
I understand that cosmetic acupuncture can cause temporary localised bruising. The vasculature of the face is delicate, especially around the eye area. Given the nature of the treatment, capillary bleeding can occur. Whilst this is not detrimental to the objective of the treatment it can be visible in form of bruising for a number of days. To achieve maximum benefit in certain delicate areas of the face, bruising is sometimes unavoidable. ☐

_____

Patient (or guardian) signature and date

_____

Patient printed name

Please take a moment to read our PRIVACY POLICY

All records will be kept confidential and will not be released without your written consent.

We retain the information we collect for as long as necessary to provide the services you have requested, or for other essential purposes such as complying with legal obligations, resolving disputes, and enforcing our agreements.

If you have not had further treatment **five years after your last visit, ALL your patient records are deleted completely**. The only exception will be for the email newsletter, where you will always have the option to unsubscribe at any time or can choose to continue receiving it long after you have ceased treatment.

To clarify: your contact details (including your mailing address, contact number, and/or email address may be used to send you relevant information, updates and/or appointment reminders. It will not be used for anything else. Ever.

You have the right to request that we erase your Personal Data in certain circumstances, before the five-year limit. Please note that there may be circumstances where you ask us to erase your Personal Data but we are legally entitled to retain it.

We do not pass on or allow access to your information to any third parties for marketing purposes. However we may pass on or allow access to your information:

1. where we are requested by you for other medical or health practitioners;
2. where we are required to do so by law, court order or other legal process;
3. where, acting in good faith, we believe disclosure is necessary to assist in the investigation or reporting of suspected illegal or other wrongful activity. This may include exchanging information with other companies and organisations for the purposes of fraud protection and credit risk reduction;
4. to protect and defend our rights or property.

You can always read the most current Privacy Policy at www.pointspace.co.uk/privacy.php.

If you have any questions about this Privacy Policy or wish to exercise any other right, please contact dataprotection@pointspace.co.uk.

_____

Patient (or guardian) signature and date

_____

Patient printed name