# Registration Form

WEST HAMPSTEAD ACUPUNCTURE
61 MILL LANE, LONDON, NW6 1NB

| **Patient Details** | |
|---|---|
| First Name: | Last Name: |
| Date of First Visit: | Gender: Male ☐ Female ☐ |
| Address: | |

| | |
|---|---|
| Mobile No. | Email: |
| Date of Birth: | Place of Birth: |
| Marital Status: | Occupation: |
| How did you hear about us? | |
| Have you had Acupuncture before? Yes ☐ No ☐ | |
| Would you like to receive a seasonal newsletter by email? Yes ☐ No ☐ | |

| **Precautions for treatment** | |
|---|---|
| Are you pregnant? | Yes ☐ No ☐ |
| Do you have any spinal injuries? | Yes ☐ No ☐ |
| Do you have a pacemaker or any other electrical implant? | Yes ☐ No ☐ |
| Do you have a blood disorder such as anaemia or haemophilia? | Yes ☐ No ☐ |
| Do you or have you ever had a deep vein thrombosis? | Yes ☐ No ☐ |
| Are you taking anti-coagulant medication such as Warfarin? | Yes ☐ No ☐ |
| Do you have a tendency toward fainting or dizziness? | Yes ☐ No ☐ |
| Do you have any problems with your heart? | Yes ☐ No ☐ |
| Do you have any allergies? | Yes ☐ No ☐ |
| Have you ever been diagnosed with an infectious disease, such as HIV/AIDS or hepatitis B or C? | Yes ☐ No ☐ |

**Patient Consent**

**About Acupuncture:** Acupuncture is a therapy in which fine needles are inserted into specific points on the body. Acupuncture is a very safe treatment. Side effects are extremely rare and may include bruising, weakness, infection, fainting and nausea. Single use, sterile, disposable needles are used following British Acupuncture Council standard Clean Needle Technique to maintain a safe, hygienic treatment.

**Statement of Consent**

- I understand that any information I give my practitioner will be held in strict professional confidence.
- I know that at any stage I may withdraw my consent for further treatment without the need to explain myself.
- I understand that if I am deemed to be under the influence of alcohol or illegal drugs I may be refused treatment.
- I understand that the practitioner has the right to refuse me treatment if it is felt that my medical condition requires referral
- I understand that I can refuse treatment at any time.
- I understand that there is a cancellation fee of the full price of the treatment if I do not cancel the appointment at least 24hr before the treatment is due.
- I confirm that I have read and understood the above information, and I consent to having acupuncture treatment.

Signature:

**Please Turn Over**

## Reason for Appointment

| Ailment/s | How long have you had these symptoms? |
|---|---|
| 1. | |
| 2. | |
| 3. | |

## Personal Medical History (major illnesses, surgeries, allergies, tests)

| Date | History (If you need more space, please use extra paper provided) |
|---|---|
| | |

## Family Medical History

| Relative | History |
|---|---|
| | |

## Current Medication

| Medication | Dose (per day/week) |
|---|---|
| | |

## Have you seen a GP or another therapist?

| Type of therapist | Advice/Scans/Tests | Results of treatment |
|---|---|---|
| | | |