



### Patient information and consent form

Date of consultation \_\_\_/\_\_\_/\_\_\_ Referred by \_\_\_\_\_

Name and Title \_\_\_\_\_

Address \_\_\_\_\_ Postcode \_\_\_\_\_

Home Number \_\_\_\_\_ Mobile \_\_\_\_\_

Occupation \_\_\_\_\_ Work # \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex M F Email \_\_\_\_\_

In case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone Number \_\_\_\_\_

Health Fund \_\_\_\_\_ Membership Number \_\_\_\_\_

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Main Concern: \_\_\_\_\_

When did it start? \_\_\_\_\_

Any Conditions \_\_\_\_\_

Medical Family History \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_

Diet \_\_\_\_\_

Medication \_\_\_\_\_

Surgeries \_\_\_\_\_

Allergies \_\_\_\_\_ Sleep pattern \_\_\_\_\_

Other Treatments \_\_\_\_\_

Female Clients: Are you pregnant or a possibility of being pregnant? \_\_\_\_\_

Vaccinations received \_\_\_\_\_

Have you had acupuncture before \_\_\_\_\_

**I understand by signing this form that the information provided is true to the best of my knowledge. Changes to the above should be advised upon future treatments. All given information is remained confidential at all times unless given permission. I hereby consent to the performance of acupuncture treatment and other procedures within the scope of the practice of Traditional Chinese Medicine/kinesiology A 24 hour notice for cancellation/rescheduling appointments is asked to avoid a \$50.00 cancellation fee.**

Signed consent \_\_\_\_\_ (parent/guardian)

Print name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_