Juliet Adela Burns
Acupuncture Lic Ac, BA, BSc (Hons)

T: 07931 777 868 E: info@juliet-acupuncture.co.uk

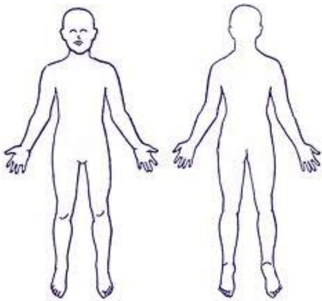
PATIENT INFORMATION	CONTACT INFORMATION
Date ______	Occupation ______
Name ______	Home Phone ______
Address ______	Mobile Phone ______
______	Email ______
Date of birth______ Age______	
Doctor's name and address ______	Another person we may contact if needed:
______	Name ______
Doctor's phone number ______	Relationship ______
Do you give consent for us to get in contact with your GP? Yes/No signed:	Phone______
How did you hear about us ______	
What are your treatment goals?	

______

______

______

On the figures below, please mark the areas of concern/pain:



Sensations/pain characteristics (circle):

Sharp Burning Moving Tingling Dull
Severe Shooting Throbbing Numbness

What relieves the pain (ice, rest, activity, massage, heat)?

______

What aggravates the pain (weather, heat, cold, rest, activity)?

______

Does anything else affect the pain / discomfort?

______

Medical history

______

______

______

______

______

______

______

Family history

______

______

______

______

Current Medication

______

______

______

______

Life style
Smoking, alcohol & recreational drugs: type, amount & frequency?

Exercise: yes/ no
Type of exercise?

Diet
Please describe in general what you eat, and what do you crave? (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

What is your fluid intake throughout the day?

Types of drinks?

Energy levels on a scale of 1-10?
(10=the best)

Headaches: Yes/no

Location of headache:

Duration:

Time of day: morning afternoon evening

Type of pain: Dull/sharp/throbbing

Frequency:

Mood: Depression Anger grief worry mania anxiety

Please circle what is relevant to you

Sleep: good/bad Vivid dreams nightmare

Tired: morning Afternoon evening

Sweat: Day /Night

Body Temperature: Hot/ cold Dry mouth Thirst

Digestion: Bloating Gas Nausea pain acid Heart burn

Appetite: Good/ bad

Bowel movement:
How often?

constipation Diarrhoea
Colour: Dark light blood mucus smell
Pain Burn itchy incomplete undigested foods

Urine:
Frequency: very often/ not much
At night: yes/no
Colour: clear cloudy dark yellow blood
pain smell burning

Cystitis Thrush

Skin: Dry greasy itchy red pale spots discharge Herpes

Heart: Chest pain Palpitations panic attack

Low/ high blood pressure

Circulation: Dizziness cold hands or feet

Breathing: Asthma Hayfever

Eyes: floaters Dry Blurry

	Ears: Tinnitus

Women only

Are you Pregnant? Yes/no How many children do you have? Miscarriages? Yes/ no	**Periods:** Regular / Irregular Length of cycle? Length of bleed? Quantity: heavy light moderate Clots: yes/no Colour: pale bright dark red brown Pain: none Dull/sharp Location of pain? When does the pain occur? Pmt? Yes/no Headaches before, after, during period?