Consent, Medical, Consultation & Case Study Form *

Patient Form

Private & Confidential

Cupping & Complementary Medicine Clinic

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Date: ……

1: Personal Details

Title & Name					
Address					
Tel		**Mob**			
Email					
Date of Birth		**Age**		**Gender**	Male/Female
Marital Status				**No of children:**	
Ethnicity:					
Occupation					
Height		**Weight**			

2: Emergency Contact

Name	
Tel	
Relationship	

3: Current Readings

Blood Pressure		**Temperature**	
Pulse Rate		**Blood Sugar Level (if diabetic)**	

4: Medical History

What is your Medical History?
Details

5: Current medical health concern

Please identify the health concern that has brought you here today?

Other concerns

6: What are your major complaints?

Details

7: Current Medication & Supplements being taken

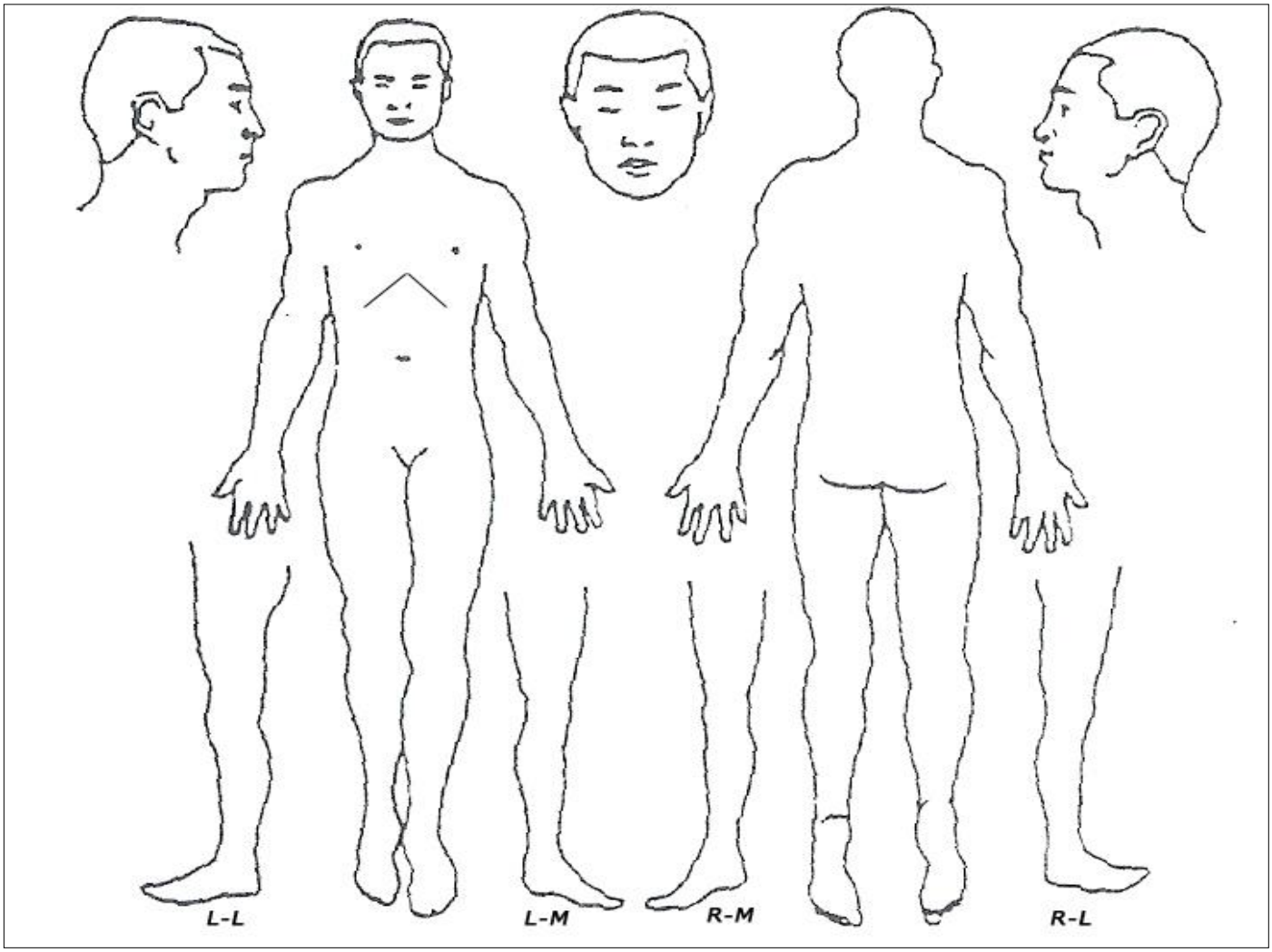
Details

Are you currently taking any of the following medication (please tick)			
[ ]	Anti-inflammatory (Aspirin, Motrin etc)	[ ]	Pain Medication/Analgesic
[ ]	Muscle Relaxants	[ ]	Birth Control Pills
[ ]	Tranquilizers	[ ]	Other

[ ]	Are you currently receiving doctor or hospital treatment	[ ]	Do you carry a medical warning card
Details			

8: Problem Areas

Please mark the location of your pain on these figures



9: Medical Check List

Please tick symptoms you currently have or have had in the past

General		[ ]	Tremors
[ ]	AIDS/HIV positive/ ARC (aids related complex)	[ ]	Stutter
[ ]	Allergies / hay fever	[ ]	Sweat easily, even with little exertion
[ ]	Anemia	[ ]	Swollen hands / feet
[ ]	Ankle swelling	[ ]	Weakness
[ ]	Arthritis	[ ]	Weight Change
[ ]	Back Pain	[ ]	Womens problems
[ ]	Blue extremities	[ ]	Varicose veins
[ ]	Bone Fracture		
[ ]	Bruise easily	**Skin**	
[ ]	Bruxism temporomandibular joint problems (TMJ) / grinding teeth	[ ]	Acne
[ ]	Cancer	[ ]	Burning
[ ]	Catch colds and flu easily	[ ]	Changing moles or lumps (cysts/tumors)
[ ]	Chills	[ ]	Dry
[ ]	Chills alternating with fever	[ ]	Eczema /hives
[ ]	Diabetes	[ ]	Itchy
[ ]	Dislocated Joints	[ ]	Moist/Clammy
[ ]	Fatigue	[ ]	Skin Rashes
[ ]	Fever	[ ]	Hair loss/thinning
[ ]	Feverish in the afternoon or hot flushes	[ ]	Dry Scalp/Dandruff
[ ]	General feeling of heaviness in the body		
[ ]	Goiter	**Ears**	
[ ]	Hair Changes/Hair loss	[ ]	Discharge
[ ]	Heat / Cold Intolerance	[ ]	Hearing trouble
[ ]	Heat sensations in the hands, feet, chest	[ ]	Pain
[ ]	Kidney Trouble	[ ]	Ringing in ears
[ ]	Mens problems	[ ]	
[ ]	Multiple Sclerosis	**Eyes**	
[ ]	Muscle spasms, twitching, cramping	[ ]	Blood shot eyes / Dry eyes
[ ]	Nail Changes	[ ]	Blurred vision
[ ]	Neck shoulder tension / pain	[ ]	Discharge
[ ]	Night Sweats	[ ]	Pain
[ ]	Numbness of hands and feet	[ ]	See floating black spots in the eyes
[ ]	One-sided pain / discomfort	[ ]	Vision Trouble
[ ]	Pain in your arms, legs or joints (knees, hips etc)		
[ ]	Pain / tenderness in the ribs	**Head**	
[ ]	Polio	[ ]	Dizziness
[ ]	Prolapsed organs (previously diagnosed)	[ ]	Epilepsy
[ ]	Rheumatic Fever	[ ]	Fainting spells
[ ]	Sciatica	[ ]	Headaches – location:
[ ]	Serious Injury	[ ]	Memory problems
[ ]	Seizure / convulsions	[ ]	Sinus congestion / pressure
[ ]	Slow healing wounds		
[ ]	Spinal Disc Disease	**Nose**	
[ ]	Stiff neck / shoulders	[ ]	Absence of smell
[ ]	Thyroid Trouble	[ ]	Bleeding
[ ]	Tuberculosis	[ ]	Pain

Medical Check List- continued

Mouth & Throat		**Heart**	
[ ]	Absence of taste	[ ]	Chest pain
[ ]	Bad breath (foul/putrid)	[ ]	Chest pain radiating to shoulder
[ ]	Bitter taste in the mouth	[ ]	Heart murmur
[ ]	Bleeding, swollen painful gums	[ ]	Heart Trouble
[ ]	Dry mouth, throat, nose or skin	[ ]	High Blood Pressure
[ ]	Frequent sore throats	[ ]	Low Blood Pressure
[ ]	Mouth sores (canker sores)	[ ]	Palpitations
[ ]	Sores on the tip of tongue	[ ]	Tight feeling in the chest
Stomach& Intestines		**Psychological**	
[ ]	Abdominal bloating or gas after eating	[ ]	Anxiety / nervousness / fidgety /restless
[ ]	Low Appetite	[ ]	Anger easily
[ ]	Excess Appetite	[ ]	Depression
[ ]	Burning sensation after eating	[ ]	Memory loss or impairment
[ ]	Constipation	[ ]	Mental sluggishness / forgetfulness / exhaustion
[ ]	Diarrhoea	[ ]	Mental/Emotional Difficulty
[ ]	Diarrhoea alternating with constipation	[ ]	Mood swings
[ ]	Feeling tired after eating	[ ]	Phobias
[ ]	Heartburn / belching		
[ ]	Nausea, gas or indigestion	**Allergies / Sensitivities**	
[ ]	Stomach pain	[ ]	Animal hair / dander /Dust/ molds /weeds/ pollen
[ ]	Stomach ulcer	[ ]	Chemicals:
[ ]	Vomiting	[ ]	Food:
		[ ]	Medication:
Lungs		[ ]	Others:
[ ]	Asthma		
[ ]	Cough		
[ ]	Difficult breathing		
[ ]	Shortness of breath (□ inhale or □ exhale)		
[ ]	Wheezing		

Since your symptoms began, have you noticed a change in			
Bowel Function		**Bladder Function**	
[ ]	Normal	[ ]	Normal color (pale yellow)
[ ]	Constipation	[ ]	Clear
[ ]	Diarrhoea/loose stools	[ ]	Dark yellow
[ ]	Bloody stools	[ ]	Reddish
[ ]	Black stools	[ ]	Cloudy
[ ]	White/light color stools	[ ]	Has odour
[ ]	Mucus in stools	[ ]	Burning
[ ]	Hemorrhoids	[ ]	Painful
[ ]	Unusually foul smelling stools	[ ]	Difficult/weak
[ ]	Colon problems	[ ]	Urgent /Inability to hold urine
[ ]	Other:	[ ]	Frequent Urination
		[ ]	Other

10: Women Patients

Please tick the appropriate responses.

Are you pregnant?			
[ ]	Yes	[ ]	Low back pain
[ ]	No	[ ]	Painful periods
[ ]	Maybe	[ ]	Blood clots
		[ ]	Irregular cycle
		[ ]	Breast lumps / tenderness
[ ]	Are you currently menstruating ?	[ ]	Difficulty conceiving
[ ]	Have you had any miscarriages ?	[ ]	Water retention
[ ]	Have you had repeated cases of miscarriages?	[ ]	Missed periods
		[ ]	Food cravings:
Menstrual Cycle – how many days?		[ ]	Fatigue when on periods
		[ ]	Vaginal Discharge
Menstrual flow is:		[ ]	Nipple Discharge
[ ]	Normal	[ ]	Vaginal Itching
[ ]	Heavy	[ ]	Endometriosis (uterus lining problems/growth)
[ ]	Light/scanty	[ ]	Fibroids (non-cancerous growths in the womb)
		[ ]	Ovarian cysts / Polycystic ovaries
Are you on birth control?		[ ]	Urinary Tract Infections
[ ]	Yes	[ ]	Polyps
[ ]	No	[ ]	Pelvic inflammatory disease
	if yes, How long?	[ ]	Headaches when on periods
[ ]	Menopausal symptoms	Operations:	
[ ]	Premenopausal symptoms	[ ]	Cervix
[ ]	PMS	[ ]	Uterus
[ ]	Bleeding between cycles	[ ]	Ovaries

Details of other problems

11: Men Patients

Details of Men's problems

12: Life Style/ Habits

	Yes	No	Daily Amount		Yes	No	Daily Amount
Coffee/Black tea				**Tobacco**			
Recreational Drugs				**Alcohol**			
Water intake				**Soda/Coke**			

Exercise Routine (eg: how many time per week, Intensity or time spent)

13: Cupping History

Have you been cupped before ?	[ ] Yes	[ ] No
If yes, how was your experience & other details		

14: Contra Indications Check list

Please tick the appropriate responses

[ ]	Have you had anything to eat?
[ ]	Are you feeling extremely hungry, thirsty or feeling weak or dizzy?
[ ]	Are you Anaemic?
[ ]	If so, what is your iron level reading?
[ ]	Do You have any vitamin/ mineral deficiencies?
	If so, Which ones?

Do you suffer from any of the following conditions?

[ ]	Low blood pressure	[ ]	Do you have liver problems
[ ]	Low pulse rate	[ ]	Do you have Kidney problems
[ ]	Low blood sugar levels	[ ]	Are you on kidney dialysis?
[ ]	Low Body temperature	[ ]	Do you have a ruptured ligament?
[ ]	Haemophilia	[ ]	Asthma, Eczema or hay fever
[ ]	Diabetes	[ ]	Bronchitis or other chest conditions
[ ]	Heart problems eg, angina, blood pressure	[ ]	Are you HIV positive?
[ ]	Have you had a Heart By-Pass?	[ ]	Have you ever had Hepatitis?
[ ]	Do you have a pace maker?	[ ]	Do you have any other infectious disease
[ ]	Do you have any device placed on/near the heart eg, stent, valves	[ ]	Do you have a tendency to faint or have blackouts or epilepsy ?
[ ]	Have you had any other major heart operation?	[ ]	Do you have a Psychological case of Insanity or Rage
[ ]	Do you bleed for a long time?	[ ]	Are your knees swollen (water on the knee ie,- *Knee effusion*)
[ ]	Are you on blood thinning medication	[ ]	Are you fearful of having blood letting treatment done?

Do you have Blood clots any where?	[ ] Yes	[ ] No
If so, where		

Do you have Cancer?	[ ] Yes	[ ] No
If so, where and what type		

Do you have any allergies e.g. penicillin, latex, foods etc…	[ ] Yes	[ ] No
If so, what from		

To the best of your knowledge are you afflicted with magic/possession/evil eye [ ] Yes [ ] No [ ] Don't Know

15: Practitioner / Treatment notes

Details

17: After Treatment (*How the patient felt*)

Details

18: Authorisation/Consent

I, the undersigned, do hereby confirm that I am the above-mentioned patient, I have read and understand the content of this form and also the before and after treatment plan.

I hereby accept full and complete responsibility for my health and all conditions thereof related. I understand and acknowledge that Health Elements, or any therapist or representative thereof make any claims, medical or otherwise, regarding the use of these services or any other products to cure or treat any disease or injury.

I understand the Cupping/Blood letting service is designed to be a health aid and is no way to take place of a doctor's care when it is indicated. Information exchanged during any session is educational in nature and should be used at your own discretion. All Client information is held in strict confidence.

I give permission to the Therapist to administer dry/massage/wet cupping on my person. I am fully responsible for this decision and do not hold the Practitioner liable for any injuries or other outcomes. The undersigned hereby forever release, discharge, acquit, and hold harmless from any and all claims, actions, suits, demands, liabilities, judgments and proceedings particularly related to or arriving from the personal demonstration of any of the above mentioned by Health Elements, or any representative thereof.

CAUTION: Bloodletting is **NOT** recommended for anyone listed in the contra-indications list or anyone who is an expectant mother except when overdue. By signing below I affirm that I am free of and do not fit into any of these categories.

CANCELLATION POLICY

I understand that unless I call or cancel my appointment within the 24 hour notice. I will be charged in full for the missed appointment.

I have read, understand and agree to all of the above.

I confirm that the information on this form is correct and accurate and no material information has been omitted. If I become aware that any of the information in this form is incorrect or out of date, I will inform my Complementary Medicine Practitioners immediately.

If you are under 18 years of age, please have your parent or legal guardian sign below.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge

Signature:_____ Date: _____

Additional Notes/ Information Update