

**Dr Seeta Raja**

**Private General Practitioner**

**MBBS Bsc MRCGP DRCOG DFSRH**

**GMC: 7084472**

Jays Pharmacy

Virginia Water, 17 Station Approach, GU25 4DW

Tel- 01344 843169

Acupuncture Pre- treatment Assessment Form(to be completed by the patient prior to appointment)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name:  Address: | Weight: | | | |
| Date of birth: | | | |
| Age: | | | |
| E mail: | Telephone/Mobile number:  Emergency Contact Name and Number: | | | |
| Please briefly describe the nature of your condition for which you feel acupuncture could help |  | | | |
| Duration of condition described above |  | | | |
| **PLEASE SUPPLY DETAILS OF YOUR PERSONAL MEDICAL HISTORY** | | | | |
|  | | **YES** | **NO** | **DETAILS** |
| Are you fit and well today? | |  |  |  |
| Any allergies including food, latex, medication? | |  |  |  |
| Do you have a tendency to faint with injections/needles? | |  |  |  |
| Any surgical operations in the past, including e.g. open heart surgery, spleen or thymus gland removal? | |  |  |  |
| Have you had any recent chemotherapy/radiotherapy or organ transplant? | |  |  |  |
| Do you suffer with anaemia? | |  |  |  |
| Do you suffer with Bleeding /clotting disorders (including a history of DVT) or are on blood thinners? | |  |  |  |
| Do you have a history of heart disease (e.g. angina, high blood pressure)? | |  |  |  |
| Do you suffer with any condition which affects your heart valves, have a pacemaker or any other implantable electrical devices fitted? | |  |  |  |
| Do you suffer with diabetes? | |  |  |  |
| Do you have any additional needs and/or disability? | |  |  |  |
| Do you suffer with epilepsy/seizures (or in a first degree relative?) | |  |  |  |
| Do you suffer with HIV/AIDS? | |  |  |  |

|  |
| --- |
| * **Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)? |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES** | **NO** | **DETAILS** |
| Do you suffer with an Immune system condition e.g. blood cancer? |  |  |  |
| Do you have a history of mental health issues (including anxiety, depression)? |  |  |  |
| Do you suffer with a neurological (nervous system) illness? |  |  |  |
| Rheumatology (joint) conditions? |  |  |  |
| Do you suffer with any conditions relating to the spleen? |  |  |  |
| Any other conditions? |  |  |  |
| Are you or your partner pregnant or planning a pregnancy? |  |  |  |

Signed by Patient (or Parent/Guardian) ……………………………… Date ………………