

**Dr Seeta Raja**

**Private General Practitioner**

**MBBS Bsc MRCGP DRCOG DFSRH**

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

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| --- | --- |
| 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? |   |   |   |

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