elements of life
HEALTH & WELLBEING

**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 ____/_____/_____