Client registration

Personal details completed: face to face ☐ by video call ☐ by phone ☐ by email ☐

Name:	Date:
Address: Post code:	
Telephone: Home: Mobile:	Work: Email:
DOB: Age:	Sex: M/F
Occupation:	
Lifestyle/interests/exercise:	

Basic medical history (please highlight relevant answer and elaborate where needed)

Medical Conditions:

Heart Problems: No/ Yes	**Blood Pressure**: ok/high/low
Epileptic: No/Yes	Last fit:
What action to take if seizure occurs? 999/ call family member? Tel:	
Diabetic: No/ Yes	Diet controlled: No/ Yes/ NA
Type 1: No/ Yes/ NA	self-administered: No/ Yes/ NA
What action to take if hypo occurs?	
Do you have any cancer history? No/Yes. **If YES please complete section on next page**	
Pregnant: No/Yes/Trying	Months: / Problems?

Medication (inc Homeopathic, etc)

Do you have any emergency medications?
Where are these located?
Please provide permission for these to be accessed if required: Sign:

Allergies

Allergy to nuts: no/yes	Metal allergies: no/yes
Sensitive to oils/creams: no/yes	Other: no/yes

Comprehensive medical history - Complete relevant sections only

Details of any operations or accidents:

Cancer history/ any areas of concern?
Present location/s
Treatment: (current or past)
Recovered: Date of discharge:

Female health:	
Are you menopausal? No/Yes	Problems?
Menstruation: Regular/irregular	Pain/heavy/other: No/ Yes/ NA

Vascular Health:		
Varicose veins: No/Yes	History of DVT: No/Yes	Leg problems: No/ Yes
Fluid retention/cellulite/cold in:	hands/feet: No/ Yes	

Digestive/ bowel health:	
Diarrhoea or Constipation No/ Yes	IBS: No/Yes
Diverticulitis: No/Yes	Blood in stool: No/Yes
Kidney or bladder issues: No/ Yes	Urination issues: No/ Yes

Pain or mobility issues:	Back problems:
Osteoporosis: No/Yes:	
Numbness: No/ Yes	Swelling: No/ Yes
Rheumatism: No/ Yes	Arthritis: No/ Yes
Joint problems: No/ Yes	Spasm/irritability: No/ Yes
Headaches: No/ Yes	Migraines: No/ Yes

Respiratory Health:	Bronchitis: No/ Yes
Asthma: No/ Yes	Prone to Infections: No/Yes
Prone to: Colds/ Sore Throat/ Sinus problems/ Other No/ Yes	

Skin Health:
Dermatitis/ Eczema/ Acne/ Psoriasis: No/ Yes

Auto immune and/ or inflammatory conditions: No/ Yes	
Do you experience Fatigue/weakness: No/ Yes	
Do you bruise easily: No/ Yes	Do you experience heavy limbs: No/ Yes

Do you have any issues with:	
Eyes?	Nails?
Ears?	Hair?
Mouth/lips?	other?

Well-being - Complete relevant sections only

Please describe the following:

Sleep patterns:
Emotional state:
Depression/ mood swings/ Nervous tension/ other

Do you:

Smoke: No/ Yes	How many:	
Drink alcohol: No/ Yes	Qty/frequency:	
Drink Tea: No/ Yes	Normal: No/ Yes	Herbal: No/ Yes
How much?		
Drink Coffee: No/ Yes	Regular: No/ Yes	Decaf: No/ Yes
How much?		
Drink Water: No/ Yes	How much?	
Drink other liquids: No/ Yes		
Experience thirst/ lack of thirst: No/ Yes		

Have a balanced diet: No/ Yes	Eat regular meals: No/ Yes
Have a good appetite: No/ Yes	Sense of taste: Good/ Poor
Have digestive problems: No/ Yes	
Indigestion: No/ Yes	Reflux: No/ Yes
Stomach pains: No/ Yes	Other:

Where relevant please provide an overview of your average diet:

Breakfast:
Lunch:
Evening:
Other:

Any other details medical or otherwise not yet identified: No/ Yes

Are you attending for:

General wellbeing: (accessing therapies as and when): No/ Yes
Support with pain or an ongoing issue? (where a course of sessions is required): No/ Yes

Please summarise why you are attending and any desired outcomes:

To be completed by therapist

Plan of action:

GP card given: Yes/No		
Therapy: Acupuncture, Auricular Acupuncture, Massage, Reiki, Aromatherapy **Reason for visit:** Pain, Tension, Stress, Wellbeing, Other **Medical concerns:** Diabetic, BP, Heart problems, Cancer, Transplant, Other		
GP concerns raised (if any) **Date:**		
Consent to communicate with these professionals: Yes/No		
GP:	Surgery:	Tel:
Consultant:	Located:	Tel:

1. Payment is made at the end of your appointment by cash/card/PayPal via QR code or bank transfer BEFORE your appointment.
2. If you require a receipt, please ask for one at the time of your appointment.
3. If you are unable to keep your appointment or wish to change it please give **24hrs notice** or you will be charged the full fee. If you arrive late, or do not attend, therapy may be refused and you will be charged.
4. All communication with other professionals will be compliant with confidentiality laws.
5. Therapy with Heather Fields does not supersede or replace medical intervention.
6. If accompanying a minor…A Doctor MUST be consulted concerning a child's health.

- I have been suitably informed about complementary and natural health methods used and I understand the information given.
- I declare that the information I have given is true. I understand that any information withheld which may affect my therapy is done so at my own risk.
- I understand that I am receiving supportive therapy that addresses my disharmonies and is not intended to 'treat' a medical condition. I should expect a course of sessions which will be reviewed regularly and may need to be adjusted to suit my personal circumstances.
- I understand that certain treatments (cupping) can temporarily mark my skin.
- I understand that following Acupuncture I cannot give blood for 4 months.
- I consent to receiving treatment by complementary therapy.

Thankyou for your consideration

I confirm that I have checked my details in person and these are all correct

Signed:	Date:
Name printed:	DOB: