



PATIENT INTAKE FORM
for treatment with Ka Hang Leungk

Date: _____ Name: _____

Name of Parents/Guardians (if under 18): _____

Address: _____

Date of Birth: _____ Age: _____ Occupation: _____

Telephone: Mobile _____ Home _____

Email: _____

Would you like to receive the Pointspace Newsletter? You can unsubscribe at any time. Yes No

Emergency contact name & phone number: _____

Name & address of GP: _____

Current medications / dosages: (Include over the counter, supplements, vitamins, herbs)

In order of importance, reasons for seeking treatment:

1.

2.

3.

How did you hear about us? If website, please specify _____

Referred by: _____

Have you had acupuncture before? From whom? _____

Signature: _____ Date: _____

Name _____ Date _____

1. Health History: Have you ever been diagnosed with any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Tension headaches | <input type="checkbox"/> Coronary disorder or heart attack | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Lung or respiratory disorder | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> TMJ disorder | <input type="checkbox"/> Liver disease or hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back pain or sciatica | <input type="checkbox"/> Urinary of bladder infection | <input type="checkbox"/> Seizure or epilepsy |
| <input type="checkbox"/> Chest pain or angina | <input type="checkbox"/> Kidney disorder or kidney stones | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Gallbladder disorder or gall stones | <input type="checkbox"/> Cancer or tumours |
| <input type="checkbox"/> Pelvic or genital pain | <input type="checkbox"/> Spleen or lymphatic disorder | <input type="checkbox"/> HIV+ or AIDS |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Gastric or peptic ulcer | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Irritable bowel syndrome or colitis | <input type="checkbox"/> Polio or mononucleosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Allergies or hayfever |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Hypoglycaemia | <input type="checkbox"/> Asthma or bronchitis |
| <input type="checkbox"/> Bone fracture/joint sprain | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Muscle spasm or tremor | <input type="checkbox"/> Dysmenorrhoea (painful menstruation) | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Pre-menstrual syndrome | <input type="checkbox"/> Attention deficit disorder |
| <input type="checkbox"/> Tennis elbow | <input type="checkbox"/> Prostate or vaginal disorder | <input type="checkbox"/> Obsessive-compulsive |
| <input type="checkbox"/> Frozen shoulder | <input type="checkbox"/> Skin disorder, eczema, psoriasis | <input type="checkbox"/> Panic attacks or phobias |
| <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Raynaud's disease | <input type="checkbox"/> Major depression |
| <input type="checkbox"/> Shingles (herpes zoster) | <input type="checkbox"/> Deafness or tinnitus | <input type="checkbox"/> Schizophrenia |

2. Accidents: Have you ever been injured in any of the following types of accidents?

- | | | |
|--|--|---|
| <input type="checkbox"/> Automobile accident | <input type="checkbox"/> Work-related accident | <input type="checkbox"/> Accident at home |
| <input type="checkbox"/> Athletic injury | <input type="checkbox"/> Surgical complication | <input type="checkbox"/> Other accident |

3. Current Conditions: In the past year, have you noticeably experienced any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain in legs or feet | <input type="checkbox"/> Large weight gain or weight loss | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Pain in arms, wrist, hands | <input type="checkbox"/> Overeating or binge eating | <input type="checkbox"/> Colds, flu or chills |
| <input type="checkbox"/> Cold hands or cold feet | <input type="checkbox"/> Under eating or poor appetite | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Swollen ankles or feet | <input type="checkbox"/> Craving for sweets or chocolate | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Stiff, aching joints | <input type="checkbox"/> Craving for drugs or alcohol | <input type="checkbox"/> Diarrhoea |
| <input type="checkbox"/> Neck or shoulder tension | <input type="checkbox"/> Dissatisfaction with job | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Grinding your teeth | <input type="checkbox"/> Bored or uninterested in things | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Loneliness or lack of affection | <input type="checkbox"/> Lethargy, fatigue |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Sex life not satisfying | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Thoughts of killing yourself | <input type="checkbox"/> Disturbing dreams |
| <input type="checkbox"/> Dizziness or fainting | <input type="checkbox"/> Worried about finances | <input type="checkbox"/> Relationship problems |

4. Substances or Medications: In the past several months, did you regularly take any of these?

- | | | |
|---|--|--|
| <input type="checkbox"/> Cigarettes or cigars | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Several cups of coffee/day | <input type="checkbox"/> Prescribed pain reliever medication | <input type="checkbox"/> Anti-anxiety pills |
| <input type="checkbox"/> Glass or beer or wine | <input type="checkbox"/> Recreational drugs/marijuana | <input type="checkbox"/> Anti-depressant pills |
| <input type="checkbox"/> Liquor or mixed drinks | <input type="checkbox"/> Several cans of soft drink/day | <input type="checkbox"/> Blood pressure pills |



ACUPUNCTURE INFORMATION and INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me by Ka Hang Leoungk, MBACc.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion and cupping.

Side effects such as local bruising, broken needles, pain at site of insertion, pneumothorax, spontaneous miscarriage are rare but possible. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. **I will notify the practitioner if I am or become pregnant. I will notify the practitioner if I have a bleeding or other serious health disorder.**

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the practitioner thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

Payment in full is expected at the time of service. **I understand that should I need to cancel an appointment, at least 24 hours notice will be given. I understand that I will be charged the full treatment fee for missed or cancelled appointments with less than 24 hours notice.**

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ADDITIONAL INFORMATION FOR COSMETIC ACUPUNCTURE (please tick after you've read this):

I understand that cosmetic acupuncture can cause temporary localised bruising. The vasculature of the face is delicate, especially around the eye area. Given the nature of the treatment, capillary bleeding can occur. Whilst this is not detrimental to the objective of the treatment it can be visible in form of bruising for a number of days. To achieve maximum benefit in certain delicate areas of the face, bruising is sometimes unavoidable.

Patient (or guardian) signature and date

Patient printed name



Please take a moment to read our PRIVACY POLICY

All records will be kept confidential and will not be released without your written consent.

We retain the information we collect for as long as necessary to provide the services you have requested, or for other essential purposes such as complying with legal obligations, resolving disputes, and enforcing our agreements.

If you have not had further treatment **five years after your last visit, ALL your patient records are deleted completely.** The only exception will be for the email newsletter, where you will always have the option to unsubscribe at any time or can choose to continue receiving it long after you have ceased treatment.

To clarify: your contact details (including your mailing address, contact number, and/or email address may be used to send you relevant information, updates and/or appointment reminders. It will not be used for anything else. Ever.

You have the right to request that we erase your Personal Data in certain circumstances, before the five-year limit. Please note that there may be circumstances where you ask us to erase your Personal Data but we are legally entitled to retain it.

We do not pass on or allow access to your information to any third parties for marketing purposes. However we may pass on or allow access to your information:

1. where we are requested by you for other medical or health practitioners;
2. where we are required to do so by law, court order or other legal process;
3. where, acting in good faith, we believe disclosure is necessary to assist in the investigation or reporting of suspected illegal or other wrongful activity. This may include exchanging information with other companies and organisations for the purposes of fraud protection and credit risk reduction;
4. to protect and defend our rights or property.

You can always read the most current Privacy Policy at www.pointspace.co.uk/privacy.php.

If you have any questions about this Privacy Policy or wish to exercise any other right, please contact dataprotection@pointspace.co.uk.

Patient (or guardian) signature and date

Patient printed name