

Consultation Form

Thank you for taking the time to fill this in. You can type straight into the boxes and tick the checkboxes on your computer or phone, then save the file and email it to ela@zestacupuncture.co.uk before your first visit. You are also welcome to print it and bring it with you. Everything you share is confidential.

About you

Full name	Age	Today's date

Mobile	Email

☐ I do not wish to receive occasional newsletters by email (tick to opt out). Every newsletter also has an unsubscribe link.

Occupation	Relationship status (optional)

What do you do repeatedly at work? (e.g. sitting at a computer, lifting, driving, standing)

GP practice name

Emergency contact: name	Emergency contact: phone

How did you hear about me? (optional)

Safety check

Please answer these so I can keep your treatment safe. If you are unsure, tick "Yes" and we will talk about it.

	Yes	No
Are you pregnant, or could you be pregnant, or are you trying to conceive?	☐	☐
Do you have a pacemaker or any other electrical implant?	☐	☐
Do you take blood-thinning medication (e.g. warfarin, apixaban, daily aspirin)?	☐	☐
Do you have a bleeding or clotting disorder, or bruise very easily?	☐	☐
Do you have epilepsy or a history of seizures?	☐	☐
Do you have diabetes?	☐	☐
Do you have a blood-borne infection (e.g. hepatitis B or C, HIV)?	☐	☐
Do you have damaged or artificial heart valves, a weakened immune system, or any other particular risk of infection?	☐	☐
Have you ever had a fit, or fainted (including during injections, blood tests or at the sight of needles)?	☐	☐
Are you very anxious about needles, or would you prefer a needle-free treatment?	☐	☐
Do you have an allergy to metals (e.g. nickel), latex, or massage oils?	☐	☐
Do you have a skin condition, wound or recent injury where you would like treatment?	☐	☐

Medications and supplements

Please list everything you take regularly, including the pill, HRT, inhalers, and any herbs or vitamins.

Medications (name and dose)

Supplements, vitamins or herbs

Your main concern

What would you most like help with?

When and how did it begin? What makes it worse? What makes it better?

What does this problem affect? (tick all that apply)

- | | | |
|---|---|--|
| ☐ Walking, standing or sitting | ☐ Lying down or bending | ☐ Exercise |
| ☐ Sleep and rest | ☐ Recreation and hobbies | ☐ Work |
| ☐ Social life | ☐ Family life | ☐ Sexual life |
| ☐ Confidence | ☐ Emotions | ☐ Mental well-being |

Other concerns you have (secondary complaints)

Your medical history

Surgeries, invasive procedures or serious illnesses (please name, with approximate year)

Family medical history: has anyone in your close family had any of these? (tick all that apply)

- | | | |
|--|--|--|
| ☐ Heart disease, heart attack | ☐ Stroke, arteriosclerosis | ☐ High blood pressure |
| ☐ Low blood pressure | ☐ Arthritis, gout | ☐ Diabetes |
| ☐ Pneumonia, tuberculosis | ☐ Hepatitis, jaundice | ☐ Cancer |
| ☐ Thyroid (under or overactive) | ☐ Epilepsy, seizures | ☐ Multiple sclerosis |
| ☐ Mental illness | ☐ Other (please add in notes) | |

Women's health

Please skip this section if it does not apply to you.

Date of your last period	Average cycle length (days)	Period length (days)

	Yes	No
Is your cycle regular?	☐	☐
Are your periods painful?	☐	☐
Do you use contraception? (if yes, please give type and how many years below)	☐	☐
Are your periods changing, or have they stopped (perimenopause or menopause)?	☐	☐

Contraception: type and years	Number of pregnancies and children

Anything else about your cycle, pregnancies, births or menopause you would like me to know

Signs and symptoms

Please tick everything that applies to you now or regularly. These groups follow the Five Elements of Chinese medicine; they help me see the whole pattern.

WOOD

- | | |
|---|--|
| ☐ Irritability or anger | ☐ Mood swings |
| ☐ Depression | ☐ Addictions (incl. alcohol, drugs) |
| ☐ Indecisive | ☐ Headaches or migraines |
| ☐ Red eyes | ☐ Dry or itchy eyes |
| ☐ Spots or floaters in front of eyes | ☐ Lump in the throat, difficulty swallowing |
| ☐ Clenching teeth at night | ☐ Jaw (TMJ) pain |
| ☐ Muscle cramps | ☐ Muscle twitching |
| ☐ Joints feel tight or stiff | ☐ Often awake between 1 and 3 a.m. |
| ☐ Cold hands or feet | ☐ Soft or brittle nails |
| ☐ Hard or yellow toenails | ☐ Dry heels |
| ☐ Genital itching | ☐ Herpes |
| ☐ Craving or avoiding sour foods | ☐ Numbness or paralysis |
| ☐ Difficulty digesting fatty foods | ☐ Gallbladder problems or gallstones |
| ☐ Raised liver enzymes | ☐ Fatty liver, cirrhosis or hepatitis |

FIRE

- | | |
|--|---|
| ☐ Heart palpitations | ☐ Chest pain or tightness |
| ☐ Heart attack or irregular heartbeat | ☐ Heart failure |
| ☐ Nosebleeds | ☐ Anaemia |
| ☐ Cold limbs | ☐ Sweat easily |
| ☐ Dizziness on standing up | ☐ Insomnia (waking up often) |
| ☐ Disturbing dreams | ☐ Easily startled |
| ☐ Anxiety | ☐ Restlessness or agitation |
| ☐ Shortness of breath | ☐ Poor long-term memory |
| ☐ Lack of joy in life | ☐ Laughing for no reason |
| ☐ Craving or avoiding bitter foods | |

EARTH

- | | |
|--|---|
| ☐ Low appetite | ☐ Frequent snacking |
| ☐ Bad breath | ☐ Food allergies or intolerances |
| ☐ Food cravings or addictions | ☐ Weight fluctuates |

- ☐ Unexplained weight gain
- ☐ Diarrhoea or loose stools
- ☐ Intestinal cramping or abdominal pain
- ☐ Bloating (before, during or after meals)
- ☐ Indigestion or heartburn
- ☐ Frequent use of antibiotics
- ☐ Heaviness all over
- ☐ Muscles often feel tired
- ☐ Tendency to low blood sugar
- ☐ Fatigue
- ☐ Overthinking or worrying

METAL

- ☐ Dry cough
- ☐ Nasal discharge
- ☐ Sinus problems
- ☐ Dry mouth
- ☐ Skin rashes, hives or acne
- ☐ Oily or itchy skin
- ☐ Short of breath
- ☐ Low physical stamina
- ☐ Hot palms or soles
- ☐ Dehydration

WATER

- ☐ Bladder pain or interstitial cystitis
- ☐ Frequent urination
- ☐ Bed-wetting
- ☐ Waking at night to urinate
- ☐ Aching bones
- ☐ Low or excessive sex drive
- ☐ Fearful or easily frightened
- ☐ Hair loss
- ☐ Ringing in the ears
- ☐ Sweaty palms or feet
- ☐ Night sweats

WOMEN ONLY

- ☐ Heavy bleeding
- ☐ Irregular periods
- ☐ Very light bleeding
- ☐ Before periods: abdominal cramps
- ☐ Before periods: irritability
- ☐ PCOS
- ☐ Hysterectomy
- ☐ Miscarriage
- ☐ Caesarean section, perineal tear or cut

MEN ONLY

- ☐ Low sex drive
- ☐ Premature ejaculation
- ☐ Enlarged prostate
- ☐ Vasectomy

- ☐ Constipation
- ☐ IBS
- ☐ Wind or belching
- ☐ Haemorrhoids
- ☐ Stomach ulcer or gastritis
- ☐ Pancreatitis
- ☐ Oedema (swelling)
- ☐ Bruise or bleed easily
- ☐ Nausea or vomiting
- ☐ Difficult to wake up

- ☐ Cough with phlegm
- ☐ Poor sense of smell
- ☐ Itchy, red or sore throat
- ☐ Cold sores or mouth ulcers
- ☐ Hay fever or allergies
- ☐ Sadness, grief, cry easily
- ☐ Catch colds or flu easily
- ☐ Mild fever that comes and goes
- ☐ Craving or avoiding spicy foods
- ☐ Smoking or vaping

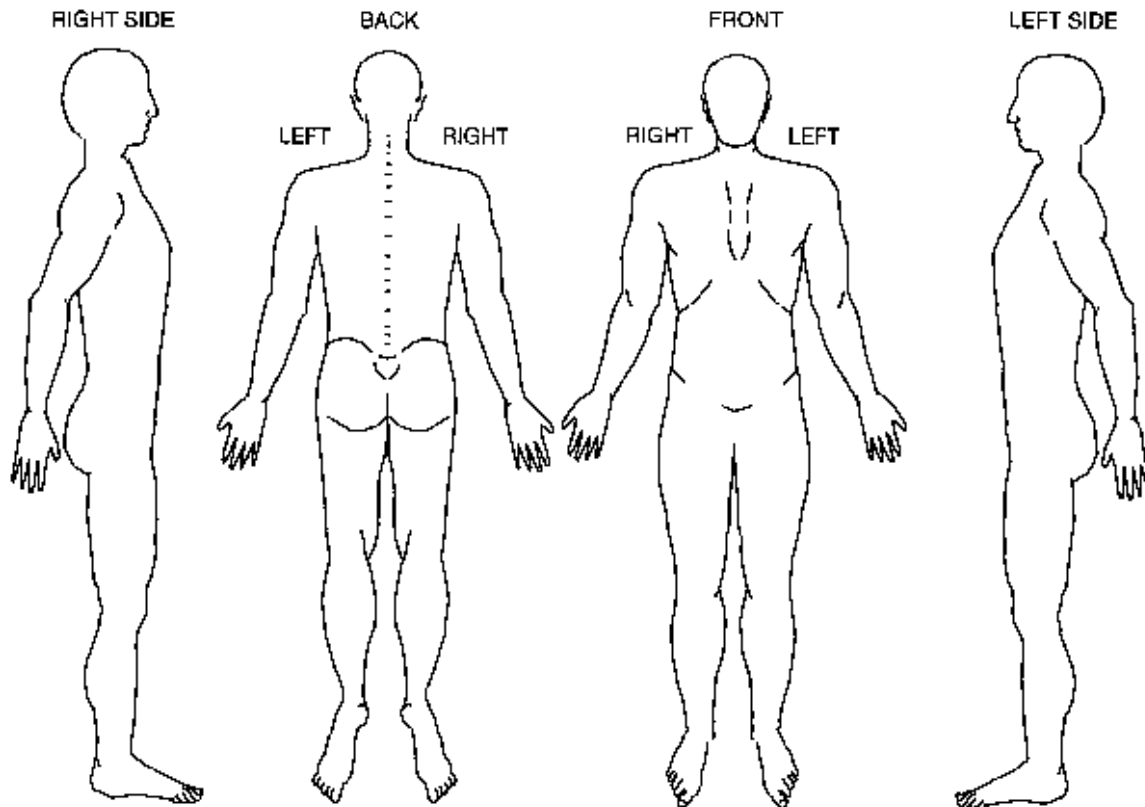
- ☐ Kidney or bladder stones
- ☐ Incontinence
- ☐ Pale, dark or cloudy urine
- ☐ Weakness or pain in lower back
- ☐ Feel the cold easily
- ☐ Little desire to drink
- ☐ Poor short-term memory
- ☐ Hearing problems
- ☐ Low fever in the afternoon
- ☐ Hot flushes
- ☐ Craving or avoiding salty foods

- ☐ Dark blood or clots
- ☐ Absent periods
- ☐ Spotting between periods
- ☐ Before periods: back or breast pain
- ☐ Vaginal discharge (yellow or white)
- ☐ Endometriosis
- ☐ Difficulty conceiving
- ☐ Pregnancy termination
- ☐ Breast lump or breast pain

- ☐ High sex drive
- ☐ Nocturnal emissions
- ☐ Erectile difficulties
- ☐ Genital itching or testicle pain

Pain assessment

If you have pain, please mark where it is. You can describe the areas below, or print this page and shade them on the diagram.



Pain scale: 1-2 light · 3-4 tolerable · 5-6 moderate · 7-8 stops most activities · 9-10 unbearable

Where is your pain, and how strong is it? (e.g. "right shoulder 6/10, lower back 4/10")

What makes your pain LIGHTER? (tick all that apply)

- | | | |
|---------------------------------------|--|---|
| ☐ Resting | ☐ Moving around | ☐ Lying down |
| ☐ Sitting | ☐ Standing | ☐ Hot shower, bath or heat pad |
| ☐ Cold weather | ☐ Hot weather | ☐ Damp weather |
| ☐ Massage | | |

What makes your pain WORSE? (tick all that apply)

- | | | |
|---|--|--------------------------------------|
| ☐ Resting | ☐ Moving around | ☐ Lying down |
| ☐ Sitting | ☐ Standing | ☐ Driving |
| ☐ Hot shower, bath or heat pad | ☐ Cold weather | ☐ Hot weather |
| ☐ Damp weather | ☐ Stress | |

About your treatment

Acupuncture uses fine, single-use, sterile needles, inserted at specific points on the body and usually left in for 15 to 45 minutes. Electro-acupuncture adds a gentle, pulsing current between some of the needles. Only single-use, sterile, disposable needles are used in this clinic.

Tui Na and bodywork use hands-on massage techniques, through clothing or with oil, together with myofascial release and visceral therapy. They soften tense muscles, mobilise joints and get blood and lymph moving.

Acupressure uses firm finger pressure on acupuncture points instead of needles.

Cupping uses special cups placed on the skin, usually for 5 to 15 minutes, to create gentle suction. It improves circulation, eases pain and tension, and helps relaxation.

Gua sha is a healing massage that uses a smooth-edged tool, stroked repeatedly over lightly oiled skin.

Moxibustion applies gentle warmth from the herb mugwort near the skin.

Safety of treatment

Treatments are generally very safe, and serious side effects are very rare. However:

- Fainting can occasionally happen, especially at the first treatment. Please eat lightly beforehand and tell me straight away if you feel faint.
- You may feel relaxed and sleepy, or energised, after treatment. If you feel drowsy, please do not drive until it passes.
- Some bruising or aching can occur. It is usually harmless and settles within about three days, occasionally up to a week after cupping or gua sha.
- Some symptoms can feel temporarily worse after treatment before they improve. Please tell me if this happens.

If there are particular risks that apply to you, I will discuss them with you before treatment.

Consent

Please read carefully and tick each box you agree with. Ask me if anything is unclear.

- ☐ I confirm that I have read and understood the information above, and that I have been informed about the treatments. I agree to receive treatment, which may include acupuncture, electro-acupuncture, massage and bodywork, cupping, gua sha, moxibustion, breathwork, sound therapy, and advice on nutrition and lifestyle. Ela will explain her approach, and I can ask questions, decline any part of treatment or stop at any time.
- ☐ My health information. The information I have given is correct to the best of my knowledge. I will tell Ela about any changes, including new medication or pregnancy.
- ☐ Medical care. I understand that acupuncture and Chinese medicine complement, and do not replace, medical care. I will continue to see my GP or specialist about my health, and I will not stop or change prescribed medication without speaking to them.
- ☐ Contacting my GP (optional). I agree that Ela may contact my GP practice if it is necessary for my care. She will always ask me first, except in an emergency.
- ☐ Photographs (optional). I agree that photographs of my tongue and ears, and of my posture where this helps my treatment, may be taken to follow my progress. I will always be asked first and can say no at any time. Photographs are kept only in my confidential record and are never shared or published.
- ☐ My data. I agree that my information is kept securely and confidentially for my treatment, for as long as professional guidelines require, as described in the privacy policy at zestacupuncture.co.uk/privacy.html. I can ask to see my record at any time.

Signature (type your full name)

Date

For clients under 18

A parent or guardian must give consent and stay in the room during treatment.

Parent or guardian: full name (typed = signature)

Relationship to client

Date

Thank you. Please save this form and email it to ela@zestacupuncture.co.uk, or bring it to your first appointment.