

Pain 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.

About you

Full name	Age	Today's date
Mobile	Email	
Address (optional)		
☐ I do not wish to receive occasional email newsletters (tick to opt out). Every newsletter 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	

Safety check

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

Do you have, or are you...	Yes	No
Pregnant, possibly pregnant, or trying to conceive?	☐	☐
A pacemaker or other electrical implant?	☐	☐
Taking blood thinners (e.g. warfarin, apixaban, daily aspirin)?	☐	☐
A bleeding or clotting disorder, or bruise easily?	☐	☐
Epilepsy or seizures?	☐	☐
Diabetes?	☐	☐
A blood-borne infection (e.g. hepatitis B or C, HIV)?	☐	☐
Damaged or artificial heart valves, a weak immune system, or a higher risk of infection?	☐	☐
Ever fainted or had a fit (e.g. during injections, blood tests or at the sight of needles)?	☐	☐
Allergic to metals (e.g. nickel), latex or massage oils?	☐	☐
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 | |



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)

Is your cycle regular?

Yes

☐

No

☐

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)?

☐☐

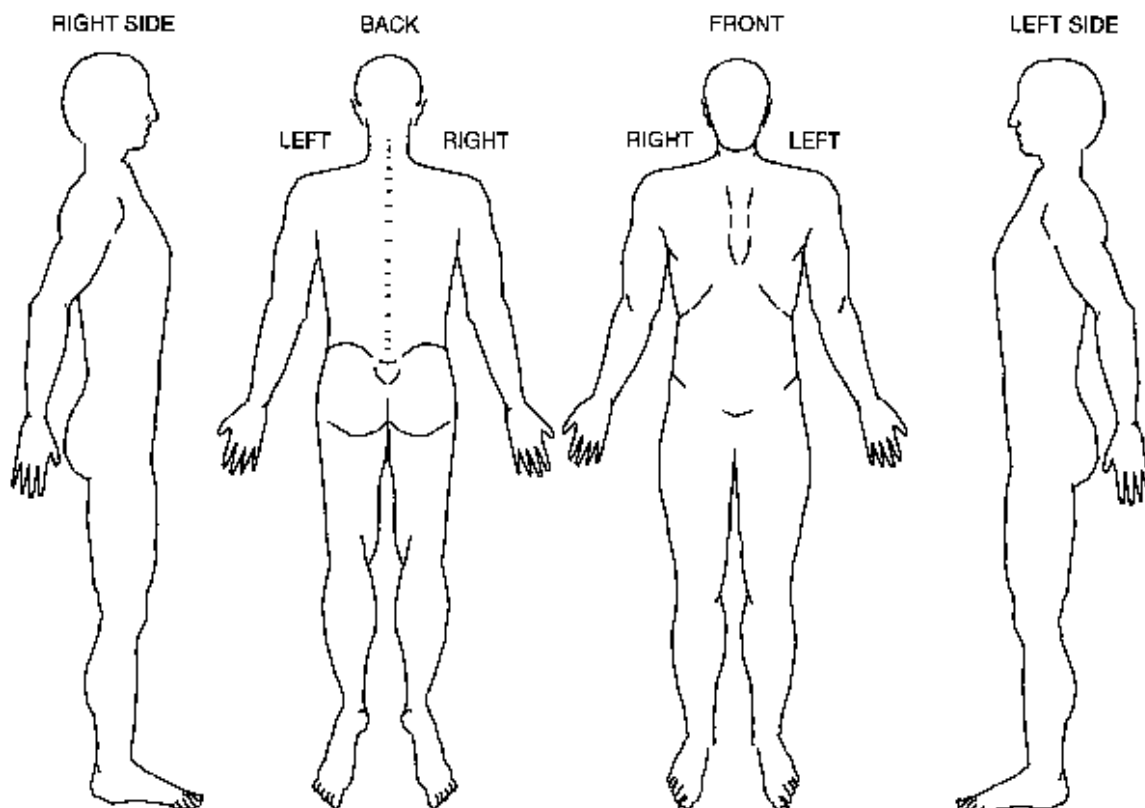
Contraception: type and years

Number of pregnancies and children

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

Pain assessment

Please mark where you feel pain. 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 | |

Additional notes

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.
- ☐ **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.