GOULDS
NATURAL MEDICINE
EST° 1881
CLINIC

ACUPUNCTURE

Name: _____ Date: _____

Gender: _____ Preferred pronouns (he/she/they): _____ D.O.B.: _____

Address: _____

Suburb: _____ City: _____ State: _____ Postcode: _____

Phone: (Home) _____ (Work) _____ (Mob) _____

Email: _____ Dr: _____

Occupation: _____ How did you find out about our clinic? _____

Do you have an Australian Centrelink issued Health Care or Pension Card? Yes ☐ No ☐

☐ Please tick if you have any conditions or physical limitations that would make it difficult to use stairs.

Do you have any known allergies to foods, medicines, animals, metals, latex or other? Y/N

If so, please list allergies: _____

Is this your first time receiving acupuncture/cupping/Chinese massage? Y/N

Please list any pharmaceutical medications (prescription and non-prescription) you are taking:

Medications (e.g., Aspirin, Nexium, Thyroxine, Digoxin; Contraceptive Pill)	**Dose & frequency**	**How long have you been taking this medication?**

I do hereby voluntarily consent to be treated with:

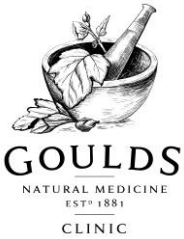
- ☐ Acupuncture
- ☐ Chinese Massage
- ☐ Cupping

administered by Jackie Pisera (registered acupuncturist). I understand that acupuncture is performed by the insertion of needles through the skin, and/or by the application of heat to the skin, at certain points on or near the surface of the body. The needles are sterilized and disposed of after single use.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and possible temporary aggravation of symptoms. I understand that acupuncture has been safely practised for centuries and adverse effects are rare. I also understand that no guarantee concerning its use and effects are given to me and that I am free to discontinue treatment at any time.

I have carefully read and understand all of the above information.

Signed: _____ Date: _____



Please indicate any known health issues you or your blood relatives have had (mother's side; father's side and siblings):

Yourself	Mother's	Father's	Siblings		Yourself	Mother's	Father's	Siblings	
☐	☐	☐	☐	Heart disease	☐	☐	☐	☐	Osteoporosis
☐	☐	☐	☐	Diabetes Type 1 or Type 2	☐	☐	☐	☐	Alzheimer's disease, dementia
☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐	Bleeding disorders
☐	☐	☐	☐	High cholesterol	☐	☐	☐	☐	Thyroid disease
☐	☐	☐	☐	Obesity	☐	☐	☐	☐	Polycystic ovarian syndrome
☐	☐	☐	☐	Breast cancer	☐	☐	☐	☐	Endometriosis
☐	☐	☐	☐	Bowel cancer	☐	☐	☐	☐	Coeliac disease
☐	☐	☐	☐	Cancer (other)	☐	☐	☐	☐	Depression, anxiety
☐	☐	☐	☐	Allergies - hay fever; asthma; anaphylaxis; eczema	☐	☐	☐	☐	Bipolar, schizophrenia
☐	☐	☐	☐	Autoimmune disease - (e.g., Hashimoto's, Graves, MS, SLE, Rheumatoid, Psoriasis)	☐	☐	☐	☐	Eating disorders
☐	☐	☐	☐	Glaucoma	☐	☐	☐	☐	Other hereditary conditions or family patterns (please specify)

Do you suffer from any blood borne communicable diseases (Hepatitis B, Hepatitis C, AIDS/HIV)? Y / N

May we have permission to contact your health professional(s)?

Doctor: _____ Suburb: _____ YES / NO

Specialist: _____ Suburb: _____ YES / NO

Personal trainer: _____ Suburb: _____ YES / NO

Psychologist/Counsellor: _____ Suburb: _____ YES / NO

Podiatrist: _____ Suburb: _____ YES / NO

Chiro/Osteo/Physio: _____ Suburb: _____ YES / NO

Other: _____ Suburb: _____ YES / NO

I give permission for my practitioner to share information about my case with other practitioners within Goulds Natural Medicine Clinic and with my General Practitioner if necessary, for the sole purpose of managing my needs effectively and safely.

Signed: _____ Date: _____

Signed by parent/guardian if under 18:

Signed: _____ Date: _____