

Acupuncture by Lenka

Medical history form

Full name

Preferred way
of addressing

Address

Email

Phone

DOB

GP/ practice

Occupation

New to acupuncture?

Yes

No

How have you
heard about me

Heart Condition / Angina

Y

N

Blood Pressure problems

Pacemaker

Blood clotting disorder

Skin complaints

Diabetes

Pregnancy

Y

N

Trying to conceive

Lymphoedema

Epilepsy/Seizures

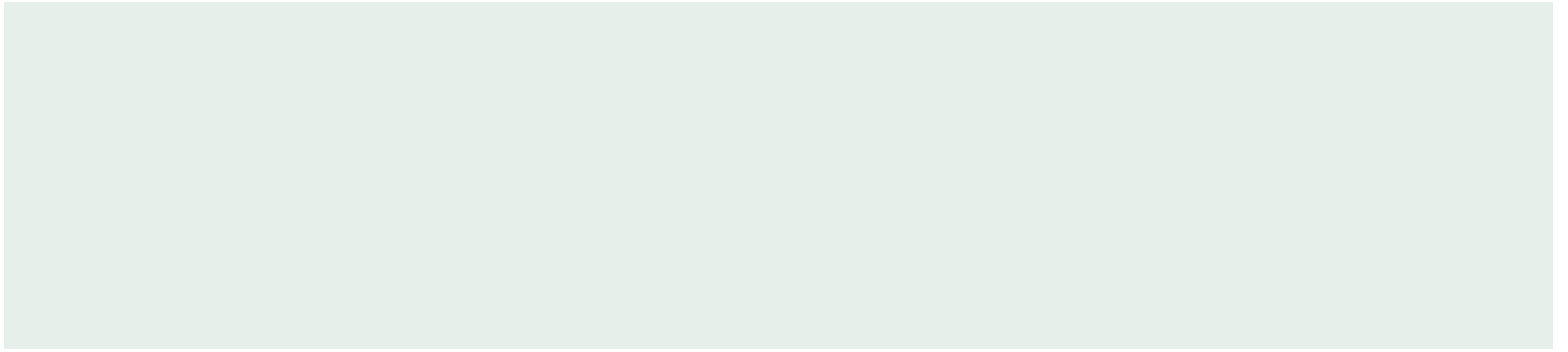
BBV (HEP B/C, HIV)

Allergic response
(metals, oils, medication)

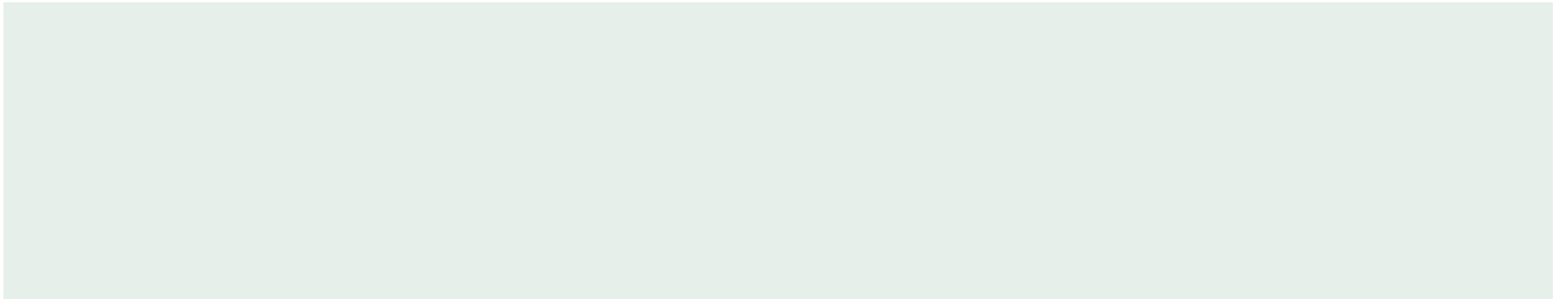
Further details if any of the answers above were yes:

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Major events, accidents, conditions, hospitalisations and operations
(including broken bones, child birth,)



Any medication, supplements, vitamins, herbs and what you take them for:



Now we've gone through the medical bit, we will move onto the nitty gritty of what brings you in. Scroll over to the next page and lets dive in...

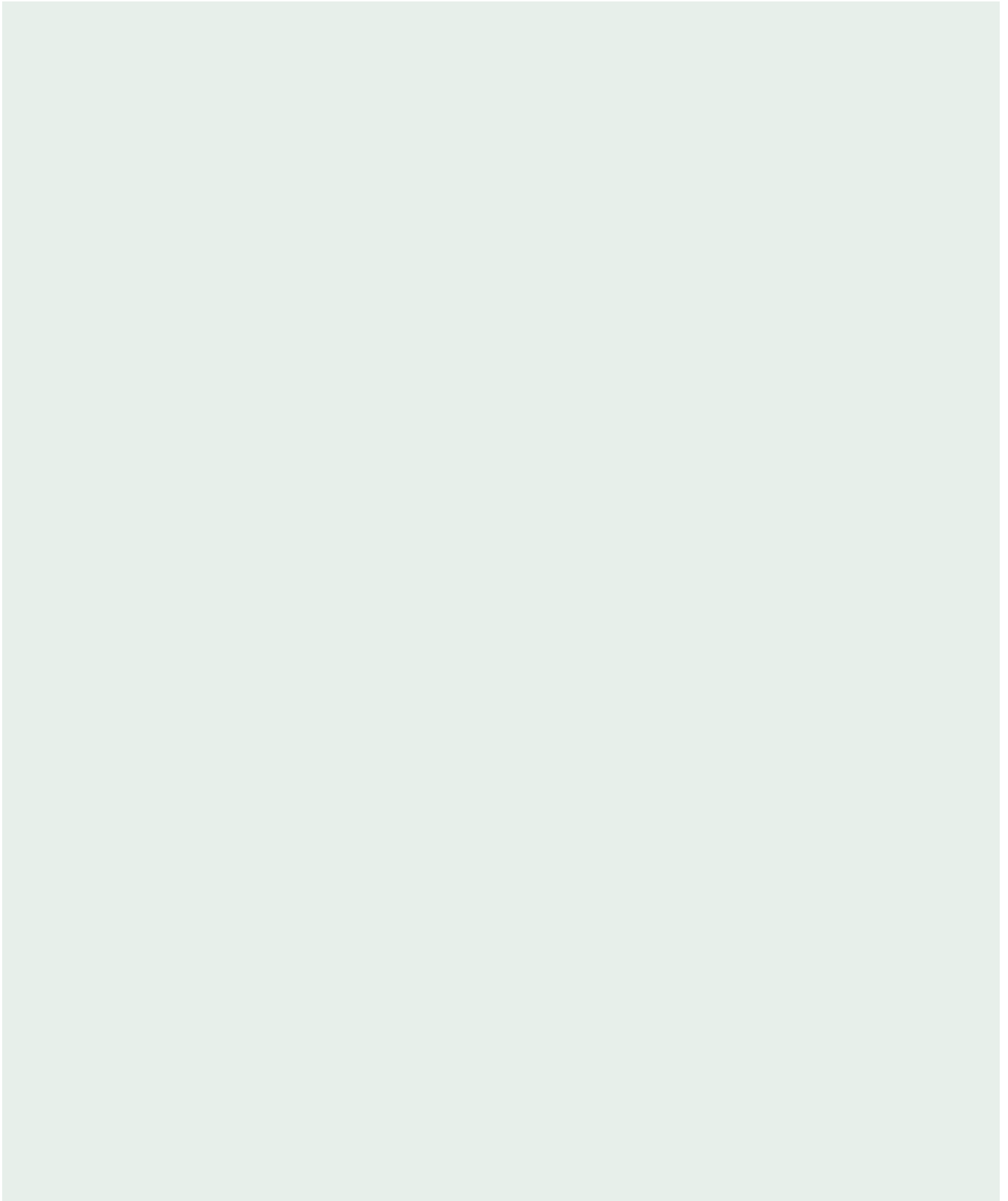
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1st and the most important thing you'd like us to focus on.

Don't hold back with any information. In your own words, please describe what is it you'd like help with. When answering please make sure you tell me when and how did it all start, whole history, what's the presentation / sensation like, what makes it better and worse, how bad is the condition out of 10 (10 being the worst), have you had any investigations or are you under a care of GP / clinic or another healthcare professional, are you taking any relief, how is it effecting you on your daily bases or in your activities

2nd thing you'd like us to focus on. Sometimes there is more to things, so don't be shy to mention if there is something else that bothers you or leave blank if not applicable.

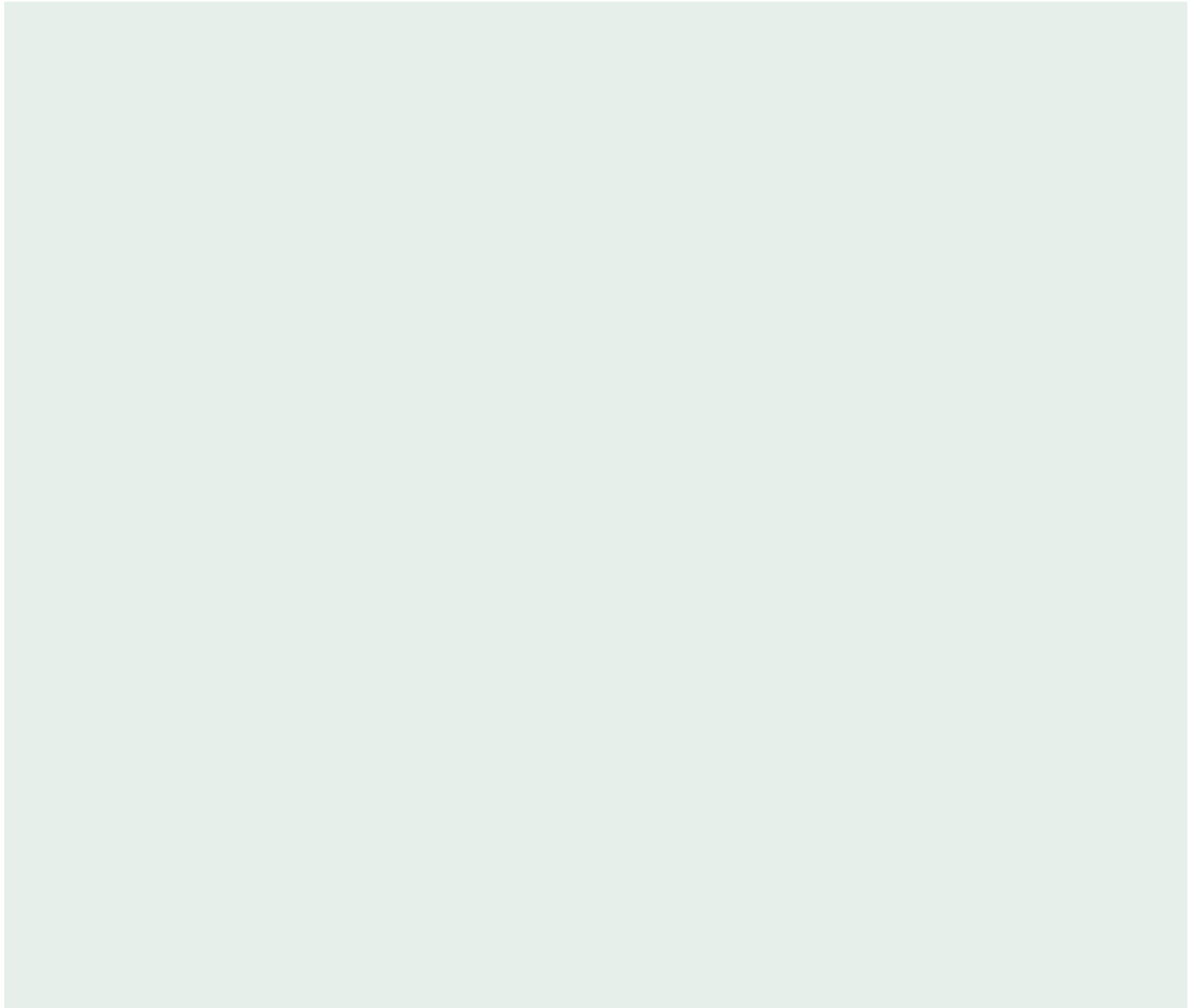
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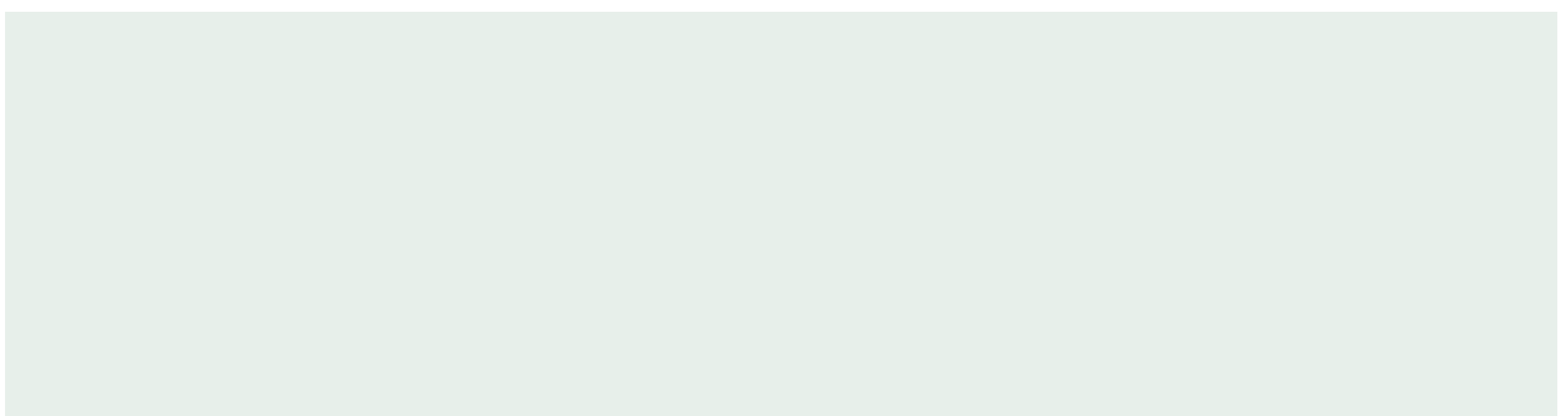
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That 3rd thing perhaps...sometimes there is more to things, so don't be shy to mention if there is something else that bothers you or leave blank if not applicable

Don't hold back with any information. In your own words, please describe what is it you'd like help with. When answering please make sure you tell me when and how did it all start, whole history, what's the presentation / sensation like, what makes it better and worse, how bad is the condition out of 10 (10 being the worst), have you had any investigations or are you under a care of GP / clinic or another healthcare professional, are you taking any relief, how is it effecting you on your daily bases or in your activities



What are your expectations / goals form the treatment:



As part of my diagnostic process we look at the body as a whole. Let's fly through the rest of other symptom and conditions.

Do you suffer with any migraines or headaches? Please fill in details (unless already described in previous section)

Do you suffer with any problems with your eyes / ears / nose/ throat / sinuses? Please fill in details (unless already described in previous section)

Do you suffer with any problems with breathing / coughing/ wheeziness or getting out of breath? Please fill in details (unless already described in previous section)

Do you feel your immune system is somewhat quite low and you catch colds easily? Please fill in details (unless already described in previous section)

Do you get any stomach pains, acid reflux , belching or indigestion ? Please fill in details (unless already described in previous section)

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Tell me more about your bowel movement, including regularity, how often do you go, tendencies towards loose / hard to pass stools or normal, any bloating or pains, any feelings of sluggish bowel, excessive wind, any occurrence of mucus or blood in stool...

Tell me more about your diet, including whether you avoid certain foods, how often would you eat, when and what (add in example) and what is your appetite like

Let's touch on your hydration habits. Roughly how much water do you drink a day? Do you prefer your water warm / room temp / cold? Do you sip or gulp? Do you also drink other fluids such as teas, coffees etc?

Do you get any troubles with your urination, such as sudden urges, incontinence, blood in urine, cloudiness, dribbling or stop/start flow, excessive/insufficient urination, waking at night for loo? Please fill in details (unless already described in previous section)

Do you drink alcohol, smoke/vape or use any recreational drugs? Please fill in details below

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Describe your sleep pattern, how many hours, feeling upon waking, any recurrent dreams / nightmares?

What are your energy levels like on average out of 10 (10 being the most) ? Describe any patterns you have noticed regards tiredness and where do you feel it mostly in the body (if applicable)

What is your temperature regulation like? Do you tend to feel cold or warm or just normal? Do you sweat excessively?

Do you feel you have good work / life balance?

Are you currently experiencing (or have you previously experienced) challenging time in relation to your mental wellbeing, particularly regards to stress, bereavement, anxiety, depression, obsessive compulsions, shock or panic. Please type in as much or as little detail you are comfortable with (unless already described in previous section)

Do you do any physical activity?

What do you do to relax?

Brill, you got to the end of the form