



ZenYoga
24a Camberwell Grove
SE5 8RE

New patient intake form

Date: ___/___/___

Name: _____ DOB: ___/___/___
Address: _____
Phone: _____ E-mail: _____
Occupation: _____ Do you enjoy your work? _____
How did you find us? _____
Doctor (or Surgery) name & address: _____

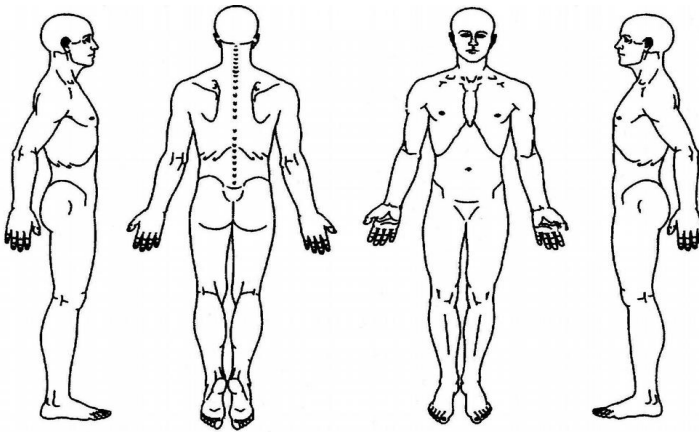
Reason(s) for treatment?

1. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse Y N
It affects your: Work Sleep Relationships Mobility Inner peace

2. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse Y N
It affects your: Work Sleep Relationships Mobility Inner peace

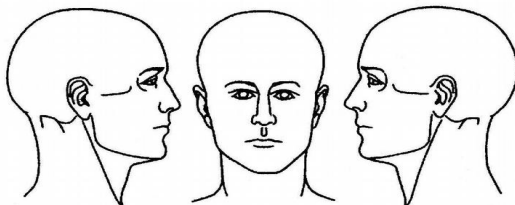
3. _____
Circle severity: 0 1 2 3 4 5 6 7 8 9 10
For how long do you have it? _____ Is it getting worse Y N
It affects your: Work Sleep Relationships Mobility Inner peace

MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS



List medication/s you're taking now:

List surgeries, traumas, injuries, accidents (and when):





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Medical conditions:

- | | |
|------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Heart disease/attack |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hepatitis (type ___) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes | |

Please tick/circle any of the following you experience either regularly or occasionally:

- | | |
|---------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Feeling unsupported |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Hayfever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> (where) _____ | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Loss/Gain of weight |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Outbursts of anger |
| <input type="checkbox"/> Constant tiredness | <input type="checkbox"/> Palpitations – At Rest/During
Activity/Randomly |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Excessive worry | |
| <input type="checkbox"/> Fear | |

Muscle / Joints / Bones:

- | | |
|-------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Tight/stiff muscles/joints | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Swollen joints (where) _____ | <input type="checkbox"/> Spine/neck/shoulder pain |

Sleep:

- | | |
|------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Difficulty getting to sleep | <input type="checkbox"/> Wake early |
| <input type="checkbox"/> Waking at night | <input type="checkbox"/> Wake exhausted |
| <input type="checkbox"/> (how often _____) | <input type="checkbox"/> Waking to pee |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> (how often _____) |
| <input type="checkbox"/> Dream disturbed sleep | |

Eyes / Ear / Nose / Throat / Respiratory

- | | |
|------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Difficulty breathing in/out | <input type="checkbox"/> Earache |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Ringing in ears (L/R/both) |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Gum/teeth trouble |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Blurred/tired/itchy/dry/sore eyes | |



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Skin:

- | | |
|----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Itching/rash |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other: _____ |

Urinary/Bowels/Digestion:

- | | |
|----------------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Diarrhoea |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Yellow/clear (other _____) | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Kidney stones/infection | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Gall stones/pain in Gallbladder | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Other: _____ |

Cardiovascular:

- | | |
|-----------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rapid/irregular heart beat | |

Gynaecological (for women):

- | | |
|---------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Menstrual cycle _____ days/irregular | <input type="checkbox"/> Bleeding between periods |
| <input type="checkbox"/> PMT/period pain – physical/emotional | <input type="checkbox"/> Thrush/bacterial infection |
| <input type="checkbox"/> Period is light/medium/heavy | <input type="checkbox"/> Previous miscarriage |
| <input type="checkbox"/> Large/small clots in period | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Lasts ___ days | <input type="checkbox"/> Infertility |
| | <input type="checkbox"/> Other: _____ |

Men:

- | | |
|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Other: _____ |

Motivations:

- | | | | |
|------------------------------------------|----------------------|---------------------------------------------|----------------------|
| <input type="checkbox"/> Energy levels | 1 2 3 4 5 6 7 8 9 10 | <input type="checkbox"/> Confidence | 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Willpower | 1 2 3 4 5 6 7 8 9 10 | <input type="checkbox"/> Self worth | 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Creativity | 1 2 3 4 5 6 7 8 9 10 | <input type="checkbox"/> Excitement in life | 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Planning | 1 2 3 4 5 6 7 8 9 10 | <input type="checkbox"/> Feeling supported | 1 2 3 4 5 6 7 8 9 10 |
| <input type="checkbox"/> Decision making | 1 2 3 4 5 6 7 8 9 10 | <input type="checkbox"/> Managing stress | 1 2 3 4 5 6 7 8 9 10 |

Anything else?

The Get Well Clinic can contact my GP if considered important Y/N



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Coming for treatment

Please arrive 5 minutes before your treatment time and bring this new patient form with you. A multibed clinic is fast-paced by nature – if you arrive late we may not be able to treat you.

Out of respect to the practitioners and other people seeking treatment, **please give 24 hours notice to cancel or postpone a treatment, otherwise you will be charged** the full treatment fee (£25 or £35) for the missed appointment.

Please wear loose clothing for easy access to legs, arms, abdomen and back so that you do not need to undress. Treatment usually lasts 45 minutes.

Acupuncture is a safe method of treatment, but on rare occasions it may induce minor bleeding, bruising, numbness or tingling near the needling sites, dizziness and fainting, which are not imposing any risks or danger to the patient's health or life.

By voluntarily signing below, I show that I have read the above consent to treatment, have been told about the risks and benefits of acupuncture, and have had an opportunity to ask questions.

Signature _____ Date: ____ / ____ / ____

The Get Well Clinic
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SE5 8RE
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George 07801 813 893
Marion 07985 903 715

