Roberta Weber New Old Medicine
Questionnaire and Consent Form

CLIENT DETAILS

Name: _____ Date of Birth: _____

Address: _____

_____ Telephone: _____

PRACTITIONER NAME: Roberta Weber, Member British Acupuncture Council & the International BodyTalk Assoc. Healing modalities utilised: Five Element Acupuncture, Auricular Acupuncture, Cupping, BodyTalk, Constellation Therapy, Biofield Tuning and Shamanic healing.

CLIENT MEDICAL HISTORY: Do you (Does the client, if completing for a person under-16) currently suffer from, or have you (they) ever suffered from any of the following?

	Y	N	DETAILS
Heart Condition/Angina			
Blood Pressure Problems			
Epilepsy/Seizures			
Haemophilia/Blood Clotting Disorders			
Blood borne Virus e.g. Hepatitis B/C or HIV			
Skin Complaints, e.g. psoriasis, eczema			
Diabetes			
Allergic Response, e.g. anaesthetics, jewellery			
Do you have an electrical implant of any kind?			
Have you been diagnosed with a tumour at any point?			
Are you currently receiving palliative care?			
Do you regularly take any blood thinning medications, e.g. aspirin			
Do you take any regularly prescribed medication? If yes, please list on the reverse with dosage and frequency.			
Could you be pregnant or are you trying to get pregnant?			
Details of any problems with previous treatments			
Are you/the client right handed?			

I declare that the information I have provided on medical history is correct to the best of my knowledge and hereby give consent for the therapies described above to be carried out by the named practitioner. I confirm that I have been provided with written information on (i) the potential complications associated with the procedure(s) and (ii) appropriate aftercare advice for acupuncture, and all other modalities and (iii) the clinic privacy statement. I give consent to the practitioner to retain the details provided on this form and in clinic notes for a period of eight years from the last session.

Further, I understand that these services are not a replacement for Licensed Medical Care, they do not provide a diagnosis and I consent to receiving bioenergetic treatment.

Signature of Client _____ Date ___/___/_____

Signature of Practitioner: _____ Date ___/___/_____ Time_____

Where Client is under 16 years old, details and consent of parent or guardian:

Name _____ Relationship to Client _____

Address _____

Telephone _____ Proof of ID provided: Y / N

Signature of Parent or Guardian _____ Date ___/___/_____

Signature of Practitioner _____Date ___/___/_____