Kay Newman

Initial Acupuncture

Date of birth	30 Jan 1956

Practitioner	Kellie Morley
Appointment	26 Aug 2023, 1:00PM
Completed	26 Aug 2023, 12:38PM

Personal Details

Now did you hear about us

- [ ] Social media
- [ ] Drive by
- [ ] Referral
- [ ] Practitioner
- [ ] Flyer
- [ ] Google
- [x] Other (Personal recommend)

What's your occupation

Retired

Are you pregnant or trying to conceive

- [ ] Yes
- [x] No
- [ ] N/A

If yes how far along are you or how long have you been trying?

Who is your emergency contact (please list name, phone number and relationship to you)

0499773244

Do you have any children? If yes what are their ages

Yes.

Reason for consultation

Please describe what you are hoping to achieve from this session?

Chronic pain

Have you or are you currently seen anyone else for this concern?

Yes

Your Current Health

Do you have any known allergies or sensitivities?

No

Are you currently on any medication or supplements?	Yes
What is your current physical activity and frequency?	Zero
Do you currently suffer from any of the following (tick all that apply)	☐ High blood pressure ☐ Migraines ☐ Anxiety ☐ Depression ☑ Dizziness ☐ Pins & Needles / tingling feelings ☐ Circulation or heart issues ☑ Blood clots or thrombosis ☑ Gastrointestinal issues (bloating, cramping, flatulence) ☐ Nerve pain ☑ Immune dysfunction / autoimmunity ☑ Back / spinal issues ☐ Heavy menstruation pain or flow ☑ Arthritis ☐ Hormonal imbalance ☐ Skin health (rashes, eczema, dermatitis, psoriasis) ☐ Sprains or strains ☐ Breathing or lung difficulties ☐ Liver or kidney disease ☐ Varicose or spider veins ☐ Muscle pain / tenderness ☐ Restrictive range of motion
Do you currently wear a pacemaker?	☐ Yes ☑ No

Client Consent & Waiver

Please read and sign:

THIS AGREEMENT AND THE CONTENTS OF THIS FILE ARE CONFIDENTIAL. DATA WILL NOT BE SHARED OUTSIDE OF THE WELL COLLECTIVE WITHOUT CLIENT PERMISSION.

THE INFORMATION DISCLOSED IS TO ASSIST YOUR ACUPUNCTURIST IN PROVIDING THE SAFEST AND MOST EFFECTIVE TREATMENT PLAN FOR YOU.

I understand the methods of treatment may include, but are not limited to acupuncture, acupressure, moxibustion, cupping, essential oils, electrical stimulation, tui-na (Chinese massage), gua-sha, exercise prescription and lifestyle counseling. I understand that results are not guaranteed.

Potential benefits of these treatments may allow for the painless relief of one's current symptoms, as well as improving balance of the body's muscles/fascia, and blood flow.

Potential risks associated with acupuncture include slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, numbness, fainting, or nausea.

Cupping commonly leaves painless, dark circular marks on the skin which fades within 3-7 days. Very rare and unusual risks of acupuncture include miscarriage, nerve damage and organ punctures. I will inform my acupuncturist if I have any condition and/or if I am taking any medication that interferes with blood clotting.

Disposable needles – To reduce the possibility of infection from acupuncture, all needles are pre-sterilized-one-time-use needles made of surgical stainless steel. After each treatment they are disposed of as medical waste, never re-used. Your acupuncturist has had training in clear needle technique and universal precautions.
I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interest. I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

Please take a moment to read and sign the following information:

- If I experience pain or discomfort during the session, I will immediately inform my therapist. I will not hold my therapist responsible for any pain or discomfort I experience before, during or after the session.
- I understand that the services offered today are not a substitute for medical care.
- I understand that my therapist is not qualified to carry out a medical examination or provide a diagnosis and I agree not to interpret their comments as medical advice.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that treatment is non-sexual in nature.
- I understand my medical information and treatment notes may be released to other, third-party, health practitioners whom I agree for my therapist to refer me to.
- I agree that my therapist will need to disclose my personal information, if required to by law.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to this treatment.

Type your full name if you consent? Kay Newman

Signature

Date 26/8/2023