Acupuncturist | Herbalist | Nutritional Therapist

Jenny McElvaney

Healthy By Nature

NEW CLIENT FORM

Patient Name ____ **Date** _______________________

General Information

Address	City				
Mobile	Occupation				
Date of Birth	Email Address				
We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:	Email	Yes	☐	No	☐
	Text	Yes	☐	No	☐
GP Name, Address and Telephone	Have you had Acupuncture before?	Yes	☐	No	☐
	Do you have Health Insurance?	Yes	☐	No	☐

Referred by: Google Search ☐ Friend/Family Member ☐ Facebook ☐ Other: _______________________

Emergency Contact | Relationship | Phone

Relationship Status:

Are you presently under a doctor's care? Yes ☐ No ☐ Who and what for?

Are there any other therapies which you are involved in? Yes ☐ No ☐ Who and what for?

Focus

What is the primary reason for seeking care at Jenny McElvaney's Practice?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

Work	☐	Standing	☐	Sexually	☐
Sleep	☐	Emotional	☐	Recreation	☐
Walking	☐	Relationships	☐	Bending	☐
Sitting	☐	Social Life	☐	Stretching	☐

Other:

What have you done about this?

Are you interested in additional therapies: Herbal Medicines ☐ Nutritional Therapy ☐ Laboratory Testing ☐

What are your health goals?

List any past or future surgeries:

List any significant trauma and when it occurred (e.g. auto accident, falls, emotional, sexual, etc.)

List exercise and sport activities you have been or are currently involved in:

Medical History

Do you have any allergies? Yes ☐ No ☐ If so, to what?

Do you take medications? Yes ☐ No ☐ If so, what types and how often?

Do you take supplements? Yes ☐ No ☐ If so, what types and how often?

Please indicate if you have or had any of the following conditions:

Pneumonia	☐	Medication Reaction	☐	Mental breakdown	☐	Gonorrhea/Herpes	☐	Mental Illness	☐
Tuberculosis	☐	Heart attack	☐	Jaundice	☐	HIV/AIDS	☐	Hypo/hyper Thyroid	☐
Hepatitis	☐	Blood transfusion	☐	Parasites	☐	High/Low Blood Pressure	☐	Premature Greying	☐
Diabetes	☐	Anaemia	☐	Measles	☐	Heart Disease	☐	Seizures	☐
Kidney Stones	☐	Obesity	☐	Syphilis	☐	Cancer	☐	Multiple Sclerosis	☐

Do you sleep well? Yes ☐ No ☐ Do you dream? Yes ☐ No ☐

Do you have a high point during the day Yes ☐ No ☐ Do you have a low point during the day? Yes ☐ No ☐

What are your indulgences?

What are your hobbies/pleasures?

Female Concerns

Date of last menstruation Is your cycle regular Yes ☐ No ☐ Is your cycle painful? Yes ☐ No ☐

Have you ever been pregnant? Yes ☐ No ☐ Birth Control? Yes ☐ No ☐ How long?

PMS ☐ Clotting ☐ Vaginal soreness ☐ Vaginal pain ☐ Discharge ☐ Other

Male Concerns

Testicle Pain ☐ Penis Pain ☐ Penis sores ☐ Discharge ☐ Premature Ejaculation ☐ Nocturnal emission ☐ Impotence ☐

Other: ____

Signs/Symptoms

☐	Abdominal pain/distension	☐	Coughing blood	☐	Haemorrhoids	☐	Muscle cramps/pain	☐	Sinus pressure
☐	Abuse survivor	☐	Dark stools	☐	Heart palpitations	☐	Nasal congestion	☐	Skin fungal infection
☐	Acid reflux	☐	Decreased libido	☐	Hiccups	☐	Neck/shoulder pain	☐	Spots in eyes
☐	Acne	☐	Depression	☐	High blood pressure	☐	Night sweats	☐	Sweat easily
☐	Bad Breath	☐	Dizziness/vertigo	☐	Increased libido	☐	Nose bleeds	☐	Sore throat
☐	Blood in stool	☐	Dry throat/mouth	☐	Indigestion	☐	Numbness	☐	Sudden energy drop
☐	Blood in urine	☐	Diarrhoea	☐	Intestinal pain/cramps	☐	Odorous stools	☐	Swollen glands
☐	Blurry vision	☐	Ear aches	☐	Irritable	☐	Pain upon urination	☐	Teeth/gum problems
☐	Breast lump/pain	☐	Enlarged thyroid	☐	Itchy eyes	☐	Peculiar tastes	☐	Mouth ulcers
☐	Bruise easily	☐	Eye pain/strain/tension	☐	Itchy skin	☐	Poor appetite	☐	Upper back pain
☐	Chest pains	☐	Excessive phlegm	☐	Joint pain	☐	Poor circulation	☐	Urgent urination
☐	Chills	☐	Colour of ____________	☐	Kidney stones	☐	Poor memory	☐	Vomiting
☐	Cold hands/feet	☐	Excessive saliva	☐	Laxative use	☐	Poor sleep	☐	Wake to urinate

☐ Concussion	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Confusion	Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Constipation	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: ________
☐ Cough	☐ Gas/belching	☐ Mouth sores	☐ Seizures	____________
	☐ Grinding teeth	☐ Mucous in stools	☐ Short temper	____________
	☐ Headache		☐ Shortness of breath	____________

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain Intensity Levels

☐ No Pain	☐ Moderate Pain	☐ Severe Pain	☐ Terrible Pain

Sleeping

☐ No problem	☐ Disturbed	☐ Very disturbed	☐ Cannot sleep

Work – Can do:

☐ Usual work	☐ 50% of work	☐ 25% of work	☐ No work

Frequency of pain

☐ 25% of time	☐ 50% of time	☐ 75% of time	☐ 100% of time

Travel

☐ No problem	☐ Moderate pain on trips	☐	☐ Severe pain

Recreation – Can do:

☐ All activities	☐ Some activities	☐	☐ No activities

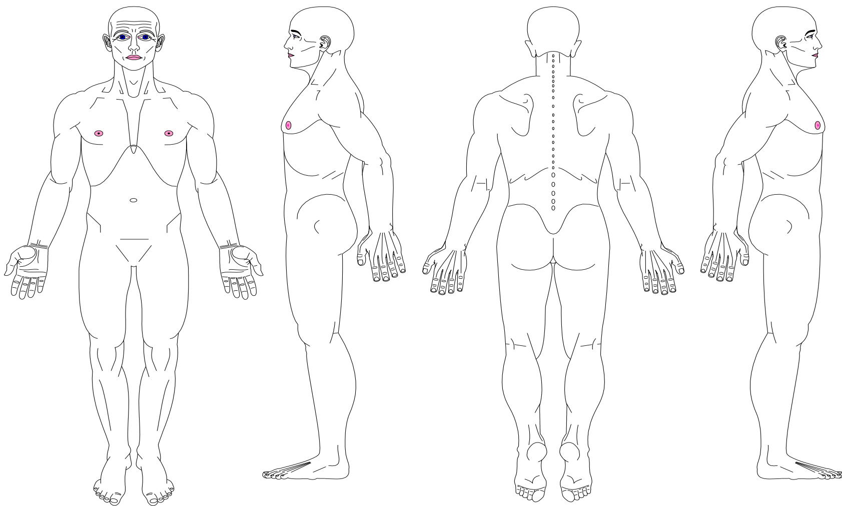
Walking

☐ Can walk fine	☐ Pain after ½ mile	☐	☐ Cannot walk

Sitting

☐ No pain	☐ Some pain	☐	☐ Cannot sit

Use the chart below to indicate pain intensity and limitations. Please mark as accurately as possible.



Pain Key

Ache	Numbness	Pins & Needles	Burning	Stabbing
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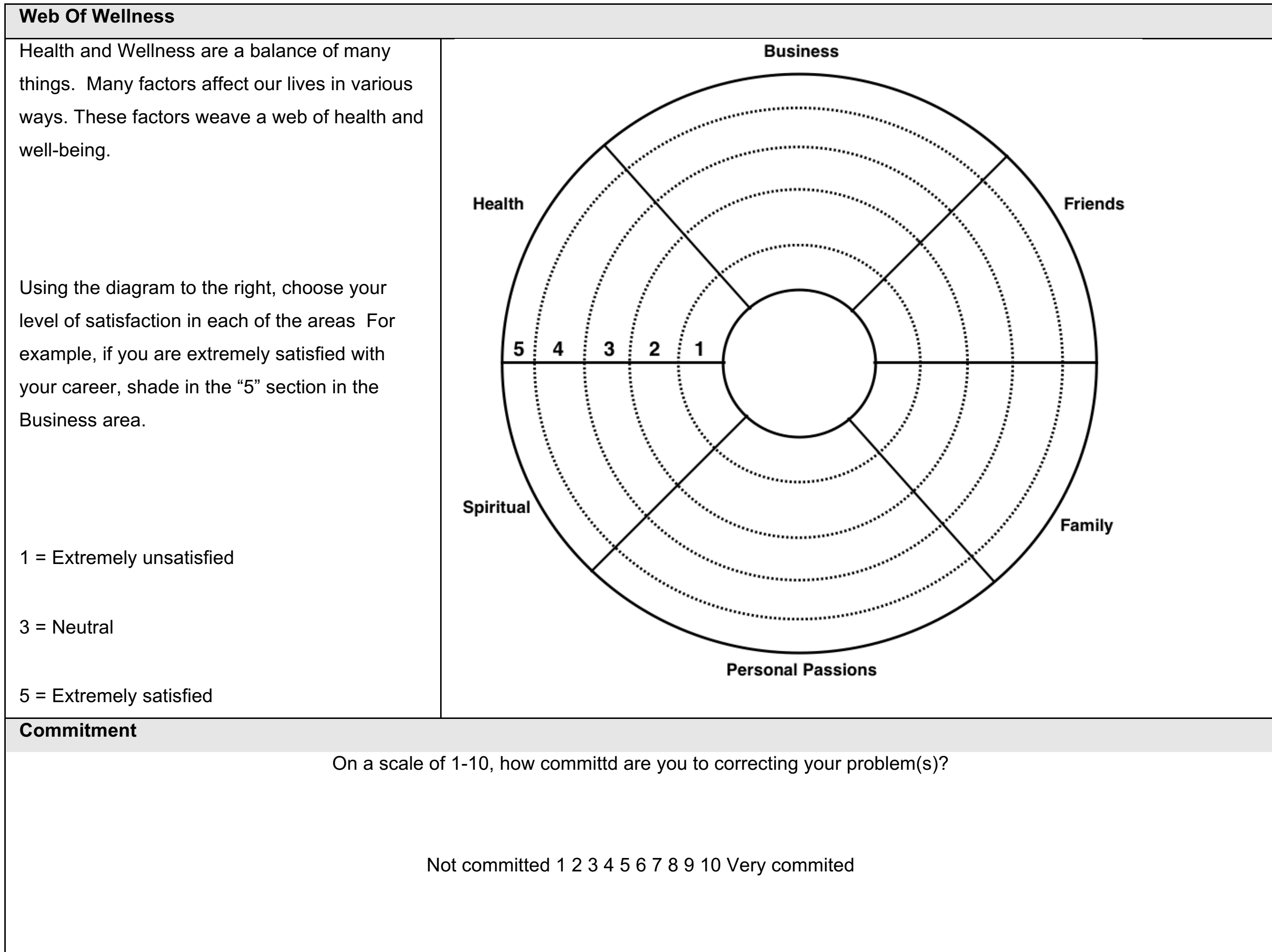

Web Of Wellness

Health and Wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas For example, if you are extremely satisfied with your career, shade in the "5" section in the Business area.

1 = Extremely unsatisfied

3 = Neutral

5 = Extremely satisfied

Commitment

On a scale of 1-10, how committd are you to correcting your problem(s)?

Not committed 1 2 3 4 5 6 7 8 9 10 Very commited

Terms & Conditions

There will be no charge for life events that are a part of everyday life and are un-avoidable.
Please try to attend appointments on time, as the clients that come after you are equally as important.
A deposit for an initial consult or total fee is required.
***If you do not cancel or simply do not attend a full fee for the consult will be charged.**

****Please ensure to wear loose, comfortable clothing to your Appointment.**

Signature Required:

I have read and agree to the terms above * ______________________________

Pay Now Acupuncture Therapy – €70.00 Pay in Full Acupuncture Therapy – €25.00 Pay Deposit **Two visits or more per week will be charged at a reduced rate of €50 per session**	**Bank Transfer** Account Name: Jennifer McElvaney BIC: ULSBIE2DXXX IBAN: IE10ULSB98502113603029 ***I am unable to take card payments over the phone.**