			Chinese Medic	ine Co	on	fidential Patien	nt Info	rm	ation			
Name:						Date of Birth:		Gender: male 🔲 female 🗌				
Address:					Sta	Post Co	Post Code:					
Home Phone:			Mo	bile:				w	ork:			
Emergency Contact (nar	no &	nho	-									
	ne a	pilo										_
Email:									Newsletter emailed to you		NO	
Occupation:			Referr	ed By: In			Doctor		Relative 🗌 Other 🗌			
GP'S Name:			S	Single 🗌		Married 🗌 Other 🗌	Name :					
Goals: what would you	like t	o ac	hieve with Chinese Medio	cine?	S	ymptoms: list in order o	of Impor	tance		Date of on	iset	
1.					1							
2.					2							
3.					3							
					_							
4.					4	-						
Have you received a dia	ignosi	is fo	r your concerns? If yes, w	hat was	the	diagnosis?						
Medications: list all Dru	gs					Supplements: list a	all vitami	ins, m	inerals & herbal medicine			
Surgery History			Da	te		Trauma History (ad	ccidents	etc.)		Date		
What do you know abo	ut yo	ur bi	irth (prolonged labour, fo	rceps,		List all known aller	rgies (foo	d, ch	emicals, drugs, seasonal, i	nsects, etc.))	
premature, etc)?												
Check the Box 🗴	st	urrent		st	urrent			st	urrent		st	urrent
		Cun		Past	Curi			Past	Curr		Past	Cun
General			Sleep			Head, Ears, Eyes, Throa	at					
Catch cold easily			Difficulty falling asleep			Headaches			Blocked nose			
Recurrent infections			Wake easily			Where:			Sinus infections			
Night sweats			Time per night?			When:			Jaw pain			
Bleed or bruise easily						Migraines			Teeth/ gum issues			
Organ prolapse			Wake up too early?			Dizziness/ vertigo			Recurrent sore throat			
Strong thirst			What time?			Fainting			Hoarseness/ loss of vo	ice		
Fatigue/ low energy	_					Earache			Tonsillitis/ swollen			
Sudden energy drops			Nightmares			Change in hearing			Sores on lips/ mouth/	-		
Weight change			Vivid dreams			Ringing in ears			Strange taste in mouth			_
Skin			Grinding			Blurry vision			Swollen glands/ lumps	<u> </u>		_
Dry skin/scalp/hair	_		Talking in sleep			Night blindness			Oral ulcers			_
Rashes/hives	_		Snoring			Colour blindness			Others			_
Itching			Circulation			Spots before eyes			Nervous System	auch -		
Eczema Warts			Cold hands or feet Swelling of hand or feet			Dry eyes Eye pain/ sore eyes			Loss of taste/ smell/ to Tingling sensations/ nu			
Acne			Blood clots			Excessive tearing			Tremors	2521101101		
Change in moles			Varicose veins			Glasses/ contacts			Where?			
Hair loss/ thinning			Edema/ swollen ankles			Facial pain			Lack of coordination/ I	balance		
Greying			Puffy eyes			Facial paralysis			Paralysis/ seizures			
Other			, 0,00			Nosebleeds			Stroke			
									Concussion			
									Other			
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Dr Paul Carter. Acupuncturist & Herbalist 231-233 Park St, South Melbourne 03 9690 1155 acupunctureaustralia.com.au

Respiratory Constpation Back Pain Vaginal dynaphies Tightness/ pressure Not daily Hand/wrist pain Vaginal dynaphies Tightness/ pressure Not daily Knee pain Ovarian cysts Pain breathing Difficulty Knee pain Ovarian cysts Pain breathing Gas/ flatulence Joint/Done problems Endometricosis Shallow Breathing Gas/ flatulence Joint/Done problems Breast Swelling / refness Coughing Blood Bad breath Osteoporosis Nipple discharge Coughing Blood Pain on urination Sciatica Other Phigm production Pain on urination Sciatica Other Pain to urination Mind & Emotions Is it possible voir pregnant Difficulty concentrating Do you practice birth control? Difficulty concentrating Do you practice birth control? Other Dribbing urination Difficulty concentrating Do you practice birth control? Other Dribing urination Deficatly concentrating	Check the Box 🗴	Past	Current	Past Current		Past	Current		Past		
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Cancellation Policy

Thank you for choosing to see Paul Carter for acupuncture/ herbal treatment. Please contact us at least 24 hours to cancel or reschedule your appointment. We often have patients on a waiting list and the more notice we have, the easier it is to make appointment times available to those who need them. We enforce a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if cancellation or rescheduling is less than 24 hours.

I ______ (please print name), have read the above policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel or reschedule with less than 24 hours' notice.

Signed (patient signature): _____

Date: _____

INFORMED CONSENT

I hereby voluntarily consent to be treated with Chinese Medicine by Paul Carter a registered acupuncturist and herbalist with The Australian Health Practitioner Regulation Agency (APHRA). I understand that treatment may involve the modalities of acupuncture, moxabustion, herbal medicine, nutritional advice, and lifestyle counselling consistent with the principles of Chinese medicine.

I understand that Paul Carter performs treatments with the insertion of acupuncture needles through the skin, or by the application of heat to the skin, or by both in an attempt to support the body's physiological functions. I understand the needles used are sterile, single use disposable needles. I understand that all of my patient records as well as information I share with Paul will be kept confidential. No records or information will be released without my written consent.

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment. I also understand that Chinese medicine is not primary care medicine and that if my symptoms worsen, new symptoms arise, or I have any concerning change in my health status I should consult a licensed medical doctor.

I understand that I should inform Paul Carter prior to being treated if I believe I might be pregnant. I understand that no guarantees concerning acupuncture's use and effects are given to me, and that I am free to stop acupuncture treatment at any time. None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate. I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

PATIENTS NAME	DATE
PATIENTS SIGNATURE (or patients representative)	
PATIENT REPRESENTATIVE NAME	

Email completed form to paul@acupunctureaustralia.com.au or bring to your initial appointment