Hijama (Cupping) Personal & Medical History

Personal History

Title_____ Forename_____ Surname_____

Date of Birth_____ Sex M/F_____ Occupation_____

Address_____

_____ Post Code_____

Telephone: Home_____ Work_____ Mobile_____

Email Address _____ Marital Status _____ No of Children _____

Person financially responsible_____ Relation to you_____

Person to contact in case of emergency_____ Tel_____

Recommended / Referred By_____

Medical History

Name of Doctor/Physician_____ Tel_____

Address _____

Are you in good health?_____ If no, explain_____

Do you have any existing illness?_____ If yes, explain_____

Have you been hospitalised in the past two years?_____ If yes, explain_____

Do you bleed excessively when cut?_____ Are you taking any blood thinning medication? (*Aspirin, Warfarin)*_____

Do you smoke?_____ If yes, how much?_____

Are you taking any medications, pills or drugs?_____ If yes, please list_____

_____

Diet: (Please mention details of the main foods you eat regularly, include a typical day) _____

_____

_____

_____

_____

Exercise: (mention type and frequency of exercise) _____

_____

_____

Do you now have or have you had any of the following? (If yes, please describe underneath in remarks)

	Yes	No			Yes	No
1. Heart Disease	☐	☐	13. Liver Disease		☐	☐
2. High Blood Pressure	☐	☐	14. Kidney Disease		☐	☐
3. Blood Disease	☐	☐	15. Hepatitis		☐	☐
4. Rheumatic Fever	☐	☐	16. Asthma		☐	☐
5. Heart Murmur	☐	☐	17. Tuberculosis (TB)		☐	☐
6. Diabetes	☐	☐	18. Aids or HIV Positive		☐	☐
7. Stroke	☐	☐	19. Allergy to:	Penicillin	☐	☐
8. Epilepsy	☐	☐		Other Antibiotics	☐	☐
9. Arthritis	☐	☐		Local Anaesthetics	☐	☐
10. Tumour (Cancer) History	☐	☐		Other	☐	☐

Hijama (Cupping) Personal & Medical History

11. Nervous Disorders	☐	☐	20. Radiation Treatment	☐	☐
12. STD (Sexually Transm Disease)	☐	☐	21. Are You Pregnant	☐	☐

Cupping History

When did you last have cupping carried out?_____ Where?_____

How did you feel cupping helped you?_____

_____

_____

Please give details of your ailments and conditions you want treated: (e.g. medical problem, multiple illnesses or general wellbeing):

Remarks _____

_____

I accept that the information I have given is true to the best of my knowledge and I have not withheld any information concerning my health.

I understand that there is possibility of developing some minor reactions - as my body adjusts to the treatment given.

I give consent for treatment to be carried out by the practitioner and that my details remain confidential, except when sharing information for data, training and research.

I also agree to assume full financial responsibility for all treatment rendered.

Signature_____ Date_____

109 Coleman Road, LE5 4LE, 0116 4489063, iinfo@alihsaan.co.uk alihsaan.co.uk
facebook.com/alihsaanleicester