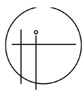

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acupuncture + wellness

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E: reneeb.tcm@gmail.com

Traditional Chinese Medicine New Patient Intake Form - Women's Health & Fertility

Date:____/____/____

Personal Information

Name ____

Address____

Suburb ________________________________

State ________________Postcode __________

Home phone____________________________________

Work phone ____________________________________

Mobile____

Email ____

Birth date ____________________Age ____________

Number of children __________Ages ____________

Marital status________________________________

Occupation________________________________

Referred by________________________________

Physician name ______________________________

Physician's phone ____________________________

May I contact? □ Yes □ No

Emergency contact name ______________________

Relationship__________________Phone ________

Main Concerns

Please list your main concerns and reasons for this appointment (symptoms, diagnosis, duration etc.)

1. ____

____

2. ____

____

3. ____

Have you seen any other doctors for this condition? If yes, please list doctor, prior interventions, and treatments ________

____

What makes your chief condition worse? (stress, fatigue, hunger, food, weather, etc.)

____

What makes your chief condition better? (rest, movement, heat, cold, eating, etc.) ________________________

____

Please mark the severity of your chief concern today.

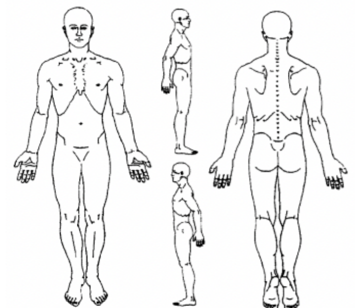
No problem ____Worst imaginable

1 2 3 4 5 6 7 8 9 10

Please mark the greatest degree of severity of your chief concern that you have ever experienced.

No problem____Worst imaginable

1 2 3 4 5 6 7 8 9 10



Please mark areas of discomfort

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Please list all current Medications / Vitamins / Herbs

Name Dosage Duration Reason

____

____

____

____

Personal Medical History

Please mark all that apply and explain as necessary

- ☐ Allergies
- ☐ Asthma
- ☐ Bleeding Tendency or on blood thinners
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness / Vertigo
- ☐ German Measles (Rubella)
- ☐ Gastric / Duodenal Ulcer
- ☐ Heart Disease / Conditions
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/Aids
- ☐ Migraines
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Other Lung Conditions
- ☐ Lupus Erythematosus
- ☐ Rheumatoid Arthritis
- ☐ Tuberculosis
- ☐ Do you take aspirin regularly?
- ☐ Do you have a pacemaker?
- ☐ Other

____

Post Hospitalisations / Illnesses / Accidents (please list and date)______________________________

____

Please date and describe significant traumas (physical or emotional)______________________________

____

List all known allergies (food, chemicals, drugs, seasonal, insects, etc.)______________________________

____

Have you undergone a course of antibiotics lately? ______________________________

Family Medical History

Please mark which apply, elaborate as appropriate and indicate which family member.

- ☐ Allergies__________________
- ☐ Asthma __________________
- ☐ Cancer__________________
- ☐ Diabetes __________________
- ☐ Drug/alcohol abuse ______________
- ☐ Heart disease______________
- ☐ High blood pressure ______________
- ☐ Mental disorder ______________
- ☐ Seizures ______________
- ☐ Stroke ______________
- ☐ Thyroid disease
- ☐ Other______________

Review of Symptoms

This section helps us to get a clear picture of any patterns of disharmony that are happening in your body. The Chinese medicine system of diagnosis can help us to target your treatment in an effective and efficient way if we find that your symptoms fall under one or two main classifications. Please check all that apply to you.

Kidney Ying/Jing Deficiency

- ☐ Do you have lower back weakness, soreness or pain or knee problems?
- ☐ Do you have ringing in your ears or dizziness?
- ☐ Do you have vaginal dryness?
- ☐ Do you have dark circles around or under your eyes?
- ☐ Is your hair prematurely grey?
- ☐ Do you have night sweats or heat up at night?
- ☐ Are you prone to hot flushes?
- ☐ Do you experience fear in your life?

Kidney Yang Deficiency

- ☐ Is your lower back sore or weak?
- ☐ Do you have lower back pain premenstrually?
- ☐ Are your feet and hands cold?
- ☐ Are you typically colder than those around you?
- ☐ Is your libido low?
- ☐ Do you wake at night/early in the morning because you have to urinate?
- ☐ Do you urinate frequently and is the urine diluted?
- ☐ Do you have early morning loose bowels?
- ☐ Does your menstrual blood tend to be dull in colour?
- ☐ Do you feel cold cramps during your period that respond to heat pack?

Spleen Qi Deficiency

- ☐ Are you often fatigued?
- ☐ Is your energy lower after a meal?
- ☐ Do you feel bloated after eating?
- ☐ Do you crave sweets?
- ☐ Do you have abdominal pain or digestive problems?
- ☐ Are your hands and feet cold?
- ☐ Is your nose cold?
- ☐ Are you prone to heaviness or fogginess in the head?
- ☐ Do you bruise easily?
- ☐ Do you have poor circulation?
- ☐ Do you have varicose veins?
- ☐ Are you prone to worry?
- ☐ Have you been diagnosed with low blood pressure?
- ☐ Do you sweat a lot without exerting yourself?
- ☐ Do you feel dizzy or light headed, or have visual changes when you stand up fast?
- ☐ Is your menstruation thin, watery or pinkish in colour?
- ☐ Are you more tired around ovulation or menstruation?
- ☐ Do you ever spot a few days or more before your period comes?
- ☐ Have you ever been diagnosed with uterine prolapse?
- ☐ Are you often sick or do you have allergies?
- ☐ Have you been diagnosed with anaemia?
- ☐ Do you have haemorrhoids or polyps?

Liver Qi Stagnation

- ☐ Are you prone to emotional depression?
- ☐ Are you prone to irritability, anger or rage?
- ☐ Do you have neck/shoulder tension?
- ☐ Do you sigh a lot?
- ☐ Do you have genital itching / pain / rashes?
- ☐ Do you suffer from PMS?
- ☐ Are your breasts sore or sensitive at ovulation?
- ☐ Do you experience premenstrual breast distension or pain?
- ☐ Have you been diagnosed with high prolactin levels?
- ☐ Do you become bloated premenstrually?
- ☐ Do you have difficulty falling asleep at night?
- ☐ Do you experience heartburn or wake up with bitter taste in your mouth?
- ☐ Do you feel your menstrual cramps in the external genital area?
- ☐ Is the menstrual blood thick and dark, or purplish in colour?

Heart Qi Deficiency

- ☐ Do you wake up early in the morning & have trouble getting back to sleep?
- ☐ Do you have heart palpitations?
- ☐ Do you have nightmares?
- ☐ Do you seem low in spirit or lacking in vitality?
- ☐ Are you prone to agitation or extreme restlessness?
- ☐ Do you fidget?
- ☐ Do you sweat excessively, especially on your chest or under your arms?
- ☐ Do you lack joy in life?

Excess Heat

- ☐ Is your pulse rate rapid?
- ☐ Are your mouth and throat usually dry?
- ☐ Are you thirsty for cold drinks most of the time?
- ☐ Do you often feel warmer than those around you?
- ☐ Do you wake up sweating or have hot flushes?
- ☐ Do you break out with red acne?

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Blood Deficiency	**Blood Stasis**
☐ Is your period light and/or do you have a long time in between periods? ☐ Do you have dry flaky skin? ☐ Are you prone to getting chapped lips? ☐ Are your fingernails or toenails brittle? ☐ Are you losing hair on your head? ☐ Is your hair brittle or dry? ☐ Do you have diminished night-time vision? ☐ Do you get dizzy or light headed around your period? ☐ Do you get shortness of breath? ☐ Do you experience palpitations (feel your heart beat in your chest)? ☐ Do you have dark spots in your vision?	☐ Is your menstrual flow ever brown in colour? ☐ Do you feel midcycle pain in your abdomen? ☐ Do you experience periodic numbness of your hand or feet? ☐ Do you have varicose veins or spider veins? ☐ Does your menstrual blood contain clots? ☐ Is your lower abdomen tender to palpation (touch)? ☐ Do you experience piercing or stabbing menstrual cramps? ☐ Do you get headaches prior to your period?
Gu Syndrome	**Dampness**
☐ Can you trace many of your health problems back to an illness that you never properly recovered from? ☐ Have you ever had an intestinal parasite? ☐ Have you ever had "Bali belly" or other acute digestive condition that you contracted whilst travelling? ☐ Do you have short-lived improvements from treatments that you've tried. ie you feel better initially but then the improvement fades with time? ☐ Do you have emotional or mental health problems that coincide with your physical symptoms?	☐ Do you feel tired and sluggish after a meal? ☐ Do you have fibrocystic breasts? ☐ Do you have cystic or pustular acne? ☐ Do you have urgent, bright or foul smelling stools? ☐ Does your menstrual blood contain tissue or mucous? ☐ Do your joints ache, especially with movement? ☐ Are you overweight? ☐ Are you prone to yeast infections and vaginal itching? ☐ Do you have damp, sticky, unformed stools?

Appetite & Digestion

☐ Has your appetite changed lately
☐ Do you have a poor appetite
☐ Are you hungry all/most of the time
☐ Do you feel foggy or low if you miss a meal
☐ Do you have abdominal (intestinal) bloating
☐ Do you have intestinal gas
☐ Do you have heartburn
☐ Do you have gurgling sounds in your intestines
☐ Do you have a nervous stomach
☐ Do you experience belching/hiccups
☐ Do you experience a bitter taste
☐ Do you have acid regurgitation
☐ Do you crave particular foods
- ▫ Sweet
- ▫ Salty
- ▫ Bitter
- ▫ Sour
- ▫ Hot or spicy

☐ Do you experience bad breath

Nutrition/Diet Information

Please describe your appetite ▫ Strong ▫ Normal ▫ Poor Do you hunger quickly? ▫ Yes ▫ No

Please list some of your favourite foods ______________________________

How many meals do you eat per day? ____________ When is your biggest meal? ______________________

Do you eat when you are worried or rushed? Yes ▫ No ▫ Do you frequently eat in between meals? Yes ▫ No ▫

Do you eat when you are not hungry? Yes ▫ No ▫ ______________ Do you eat until you feel full? Yes ▫ No ▫

How much liquid do you drink per day? ________ cups What types (water, soft drink, beer)? ________________

Do you eat raw fruits and vegetables at least twice per day? Yes ▫ No ▫ Meat products? Yes ▫ No ▫

Do you eat dairy products? Yes ▫ No ▫ Soy products? Yes ▫ No ▫

"Typical Breakfast ______________________________

____

Lunch ______________________________

____

Dinner ______________________________

____

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Do you have or experience:

Stools & Urine

- ☐ Bowel movements less than 5x/week
- ☐ Bowel movements more than 2x/day
- ☐ Blood or pus in your stools
- ☐ Stools unusually light/dark in color
- ☐ Any undigested food in your stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Alternating constipation and diarrhea
- ☐ Hemorrhoids
- ☐ Excessive gas
- ☐ A feeling of being unfinished after the stool is discharged
- ☐ Abdominal discomfort that is relieved after passing the stool
- ☐ Wake at night to urinate
- ☐ Dribbling urine
- ☐ An urgency to urinate
- ☐ Urine with a strong odour
- ☐ Burning with urination
- ☐ Incontinence
- ☐ Cloudy urine
- ☐ Blood in your urine
- ☐ Abdominal pain/cramps

Sleep

- ☐ Difficulty falling asleep
- ☐ Wake up easily during the night
- • Times per night? ________________
- • At a particular time? _____________
- ☐ Wake up too early in the am
- • What time?__________________
- ☐ Nightmares
- ☐ Vivid dreams
- ☐ Grinding teeth
- ☐ Talking in sleep
- ☐ Snoring

Emotional / Cognitive

- ☐ Nervousness
- ☐ Often stressed
- ☐ Easily angered
- ☐ Aggressive behaviour
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Over thinking
- ☐ Manic-Depression
- ☐ Depression
- ☐ ADD / ADHD
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Other __________

Musculoskeletal

- ☐ Back pain
- • Where?_______________
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Hand / wrist pain
- ☐ Foot / ankle pain
- ☐ Joint / bone problems
- ☐ Osteoporosis
- ☐ Sprains / strains
- ☐ Muscle pain/weakness
- ☐ Numbness
- ☐ Sciatica
- ☐ Herniated disc
- ☐ Carpal tunnel
- ☐ Lower body weak/ aches
- ☐ Other __________

Nervous System

- ☐ Paralysis or seizures
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Vertigo / Dizziness
- ☐ Loss of taste/smell/touch
- ☐ Tingling sensations/ numbness
- ☐ Tremors
- • Where? ________________
- ☐ Stroke
- ☐ Concussion
- ☐ Other __________

Lifestyle / Self Care

Do you allow time to relax? Yes ▫ No ▫ If yes, how? __________________

____

Do you exercise regularly? Yes ▫ No ▫

Length of activity______________ Days per week________________

Types(s) of exercise ____

How many hours per week do you work?______________________________

What are the major stressors in your life? ______________________________

Please rate the following areas:

	great	good	ok	poor	bad
Family	5	4	3	2	1
Partner	5	4	3	2	1
Libido	5	4	3	2	1
Self	5	4	3	2	1
Work	5	4	3	2	1
Exercise	5	4	3	2	1
Spirituality	5	4	3	2	1

Do you use the following?

Tobacco	frequently ▫	occasionally ▫	never ▫	Number of cigarettes per day_____	Age started______
Alcohol	frequently ▫	occasionally ▫	never ▫	Number of drinks per week ______	Type of drinks ____
Caffeine	frequently ▫	occasionally ▫	never ▫	Number of cups per day ________	Type of drinks ____
Recreational drugs	frequently ▫	occasionally ▫	never ▫	Number of times per month _____	Type of drug _____

Do you have any current or past problems with addiction or substance abuse? Yes ▫ No ▫

Substance______________________ Amount___________________ When did you quit? ___________________

Please mark those that you currently use:

- ▫ Pacemaker
- ▫ Birth Control IUD
- ▫ Contact Lenses
- ▫ Eyeglasses
- ▫ Hearing Aid
- ▫ Dentures
- ▫ Artificial Limb
- ▫ Brace (neck, arm, back)

Women Only - GYNAECOLOGICAL HISTORY

Age of first period _______________________________

When was the first day of your last period? _________________________

Are you periods regular? Yes ▫ No ▫ Number of Days between periods? ______________

Number of days of bleeding? _______________ Amount of bleeding? Light / Medium / Heavy / Clots

What colour is the bleeding? Brown / Bright Red / Dark Red / Pink

Have you ever needed medication to bring on your period? Yes ▫ No ▫

Pain with menstruation? Yes ▫ No ▫ Degree of pain: Mild / Medium / Severe

Does pain start with the onset of bleeding? Yes ▫ No ▫

Does pain begins a few days prior to the onset of bleeding? Yes ▫ No ▫

Is the pain relieved by over the counter medications? Yes ▫ No ▫ If no, what relieves the pain_____________________

Is the pain: Stabbing / Cramping / Dull / Heavy / On and Off?

Do you experience pre-menstrual symptoms (PMS)? Yes ▫ No ▫ If yes, please circle all that apply?

Breast tenderness / Cramps / Acne / Change in bowel / Bloating / Headaches / Nausea / Moodiness / Fatigue /

Night sweats / Sleep disturbances /

Other (please list) ____

Do you ovulate on your own? Yes ▫ No ▫ What Day of the cycle? _____________________________

Do you chart your cycle? BBT / Ovulation Sticks / Saliva

Do you experience pain around ovulation? Yes ▫ No ▫

Do your breasts get tender around ovulation? Yes ▫ No ▫

Do you notice stretchy clear egg white slippery cervical mucous around ovulation? Yes ▫ No ▫

Do you experience spotting mid cycle? Yes ▫ No ▫

Do you experience pain or bleeding with sexual intercourse? Yes ▫ No ▫

If yes, is pain mostly on the exterior? ____________________________________

If yes, is pain mostly internal (deep penetration)? ___________________________

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Are you experiencing vaginal discharge? Yes ▫ No ▫

If yes, what colour is the discharge? White / Yellow / Green / Pinkish / Red

Associated itching and burning? Yes ▫ No ▫

Associated with an unusual odour? Yes ▫ No ▫

Do you have a Gynaecologist? Yes ▫ No ▫

When was your last pap smear?____

What was the result? ____

Was any follow up needed? ____

Have you ever had a cervical biopsy or operation? Yes ▫ No ▫

Do you get yeast infections regularly? Yes ▫ No ▫

Do you get bladder infections regularly? Yes ▫ No ▫

Have you ever had a sexually transmitted disease? Yes ▫ No ▫ If yes, please complete the following for all that apply?

- Chlamydia Yes ▫ No ▫ When __________ Treatment __________________________
- Gonorrhoea Yes ▫ No ▫ When __________ Treatment __________________________
- Syphilis Yes ▫ No ▫ When __________ Treatment __________________________
- Herpes Yes ▫ No ▫ When __________ Treatment __________________________
- Other ______________________ When __________ Treatment __________________________

Have you ever had Pelvic Inflammatory Disease (PID) Yes ▫ No ▫

When ___________________ Where you hospitalised? _______________________________________

Have you ever used an IUD?

Have you ever used the Oral Contraceptive Pill? Yes ▫ No ▫

If yes, when and for how many years? ____

Have you ever taken Depo-Provera? Yes ▫ No ▫

Have you ever been diagnosed with any of the following conditions?

Condition	**Date**	**Treatment Details**
Fibroids / Polyps		
Endometriosis / Adenomyosis		
PCOS (Polycystic Ovarian Syndrome)		
Pelvic Adhesions		
Pelvic Abnormalities		
Ovarian Cysts		

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Have you recently undergone any of the following investigations?

Investigation	**Tick yes & provide details**
Ultrasound	
Hycosy	
Hysterosalpingogram	
Hysteroscopy	
Laparoscopy	
Laser treatment	
Hormone levels	
Thyroid function	

OBSTETRIC HISTORY

Have you ever been pregnant before? Yes ▫ No ▫

Are you currently pregnant? Yes ▫ No ▫ Unsure ▫

How long have you been trying to have a baby?____

Pregnancy Details

Date	Current/ Prior Partner	Live Birth (Y/N)	Miscarriage/ Ectopic/ Stillbirth/ Abortion	Wk	Foetal Heart (Y/N)	D&C (Y/N)	Mode of Delivery	Gender	Complications

Fertility – IVF Treatments

ART (Assistive Reproductive Technology)

Have you undergone or are you currently undergoing any of the following ART procedures:

Ovulation Induction? Yes ▫ No ▫

IUI (please give year and month)? Yes ▫ No ▫ Year _________ Month ______________

Name of fertility specialist and centre? ____

IVF

How many stimulated cycles have you had?________________

Name of fertility specialist and centre? ____

Cycl e	Date started	No. of Eggs collected	No. fertilised	IVF/ ICSI/ PICSI	No. transferred	No. frozen	FSH dose/Drugs	Positive Pregnancy Test (Y/N)	Comments
1									
2									
3									
4									
5									
6									

If you have had cancelled IVF cycles please detail below:

____

____

____

____

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Patient Information and Informed Consent Form

The TCM Registration Board requires that we have your informed consent before administering treatment.
Please read this information carefully, and ask your practitioner if there is anything that you do not understand. While acupuncture, Chinese Medicine and other treatments provided by the clinic/practitioner have proven to be highly effective in correcting conditions and maintaining overall wellbeing, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you. All treatments will be explained to you before commencement. The best way to reduce the chance or risk is to answer all questions about your health fully and honestly. If you require further information or have specific questions, please ask. The treatment fees are listed at the reception desk. If you are uncomfortable you can withdraw your consent for treatment at any stage.

What is acupuncture and associated therapies?

- Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Single-use, sterile, disposable needles are used in the clinic.
- Electro-acupuncture involves passing a gentle current through the needles so that a vibration may be felt.
- Laser acupuncture uses low level cold laser on acupuncture points.
- Cupping therapy uses suction and negative pressure to lift connective tissue, release rigid tissue and loosens adhesions. Cupping pulls stagnation, waste, and toxins to the skin level where it can be easily flushed out by the lymphatic and circulatory system.
- The Chinese herbs we prescribe are TGA listed and processed in a facility that is inspected by the Australian authorities (GMP) and screens for contaminants.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

What are the possible side effects of acupuncture and other Chinese Medicine therapies provided at this clinic?

Acupuncture can sometimes cause mild bruising or bleeding. Uncommon adverse events include fainting or muscle spasm and very rare adverse events include pneumothorax or laser eye damage.

- drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive
- minor bleeding or bruising occurs after acupuncture in about 3% of treatments
- pain during treatment occurs in about 1% of treatments
- symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign
- fainting can occur in certain patients, particularly at the first treatment.
- Bruising (looks like a circular hickey) is a common side effect of cupping;
- The herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy. Please always follow your practitioner's prescription.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Below is a list of potential risks associated with the Traditional Chinese Medicine therapies.

Possible risk	Therapy	Strategies to minimise possible risk
Pain	Acupuncture, Cupping, Electro-acupuncture	Tell your practitioner if you have sensitive skin, become uncomfortable or experience pain during treatment.
Bruising	Acupuncture, Cupping, Electro-acupuncture	Tell your practitioner if you bruise easily or have a bleeding disorder. Cupping may leave bruises that are usually painless and may last over a week. It is important to tell the practitioner if bruises in the area being cupped are cosmetically unacceptable.
Infection	Acupuncture, Cupping	It is possible to develop an infection whenever the skin is punctured so please inform the practitioner if you have a known immune deficiency so special precautions can be taken. Pre-sterilised single use needles are used in this clinic.
Burn	Moxibustion, Heat Lamp	Please advise the practitioner if you have sensitive skin and if heat used during the treatment is uncomfortable.
Relaxed or Sleepy	Acupuncture, Cupping, Moxibustion	It is common to feel relaxed or sleepy after treatment therefore avoid getting up quickly from the treatment table and give yourself time to adjust after the treatment before driving or using stairs. Avoid driving immediately if you feel very sleepy.

Drug-Herb interactions	Herbal Medicine	It is important to tell your practitioner about all medications and herbal or nutritional supplements that you are currently taking or have recently stopped taking, as interactions between herbal medicine & Western medicine are possible. Chinese herbal medicine & supplements prescribed are considered safe although some maybe toxic in large doses or inappropriate.
Fainting	Acupuncture, Cupping, Massage	Do not skip a meal before treatment. Get up slowly after treatment.
Aggravation of symptoms	Any therapy	It is possible that your symptoms could get worse after treatment. This is uncommon and usually does not last but can occur.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know:
- if you have ever experienced a fit, faint or funny turn
- if you have suffered or suffer from epilepsy or seizures
- if you have a pacemaker or any other electrical implants
- if you are pregnant
- if you have a bleeding disorder
- if you have an infectious disease or have any other particular risk of infection
- if you are taking anti-coagulants (blood thinners) or any other medication
- if you have damaged heart valves or an existing heart condition

Please be aware that the above information is required in order for this practice to provide you with appropriate health care services. Failure to disclose any information regarding your health may affect the practitioner's ability to deliver these services you safely.

Statement of Consent
I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner 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. By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Appointment Policy
I'm delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy. Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you. Occasionally, there is a problem with patient's time and, with that in mind, if you are going to be more than 15 minutes late, please call to confirm availability. A 24-hour notice for cancelled or rescheduled appointments is necessary in order to avoid the 50% of the scheduled service fee cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours. Thank you for your understanding.

Privacy Policy
The information received and collected about our clients/patients from their visit and is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Darling Health Centre and Renee Boyd Acupuncture & Wellness, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional (also we will not give, share, sell, or transfer any personal information to a third party unless required by law). The client/patient information will be stored in digital format. On occasion, Renee Boyd Acupuncture & Wellness may use client/patient information to conduct clinical studies to help us improve upon services provided.

____
Print name in full (Print name of Representative if represented by another)

____
Signature (Signature of Representative if represented by another)

____
Date