Informed Consent for Acupuncture and/or Naturopathic Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Complementary Medicine procedures on me (or the patient named below, for whom I am legally responsible) by the acupuncturist/naturopath named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, laser acupuncture, cupping & gua sha, electrical stimulation, Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counselling.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that may last a few days. There have been very rare instances reported of fainting, infection and scarring although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha.

I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach-ache, vomiting, headache, diarrhoea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I do not expect the acupuncturist/naturopath to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist/naturopath to exercise judgment during the course of treatment which the acupuncturist/naturopath thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment form have been told about the risks and benefits of acupuncture and other procedures, 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 for any future condition(s) for which I seek treatment.

_____ _____

Patient's Signature
(Parent or Guardian to sign if patient is under 18)

Patricia McNab
Acupuncturist/Naturopath

_____ _____

Print Name of Patient

Date

Are you pregnant? Yes/No

If yes, how many weeks? _____

North Brisbane chiropractic
1/711 Stafford Road
Everton Park 4053
3354 3111

Ferny chiropractic
135 Ferny Way
Ferny Hills 4055
3351 0933

NEW PATIENT QUESTIONNAIRE

(STRICTLY CONFIDENTIAL)

ADULT **Date:** _____

Personal Details

Mr/Mrs/Miss/Ms_____

Given Name Middle Name Surname

Address: _____

_____ Post Code _____

Telephone: (Home) _____ (Mobile) _____

(Work) _____ (Email) _____

Date of Birth: / / Age: ___ Number of Children: ___ Partners Name: _____

Occupation: _____

Person Responsible for accounts: _____ Health Fund: _____

Referral Details

Who can we thank for referring you to us:

Family/ Friend (name) _____ ☐ Yellow Pages ☐ Saw Sign

☐ Health Fund ☐ Acupuncture/Naturopathic Association ☐ Gym

☐ Health Care Practitioners ☐ Local Paper ☐ Internet

Accidents or Injuries

List any accidents or injuries:	Date		Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Medical Doctor is: _____ Phone Number: _____

Health Details

Medications currently taken: ☐ Pain Killers ☐ Muscle Relaxants

☐ Anti- Inflammatory ☐ Birth Control ☐ Blood Pressure ☐ Vitamins ☐ Herbs

Please list any other: _____

_____

List any Operations:	Date		Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Our purpose is to educate and treat as many families as possible towards optimal health through acupuncture and/or naturopathic care.

***Do you suffer from any of the following*:**

Headaches	Shortness of Breath	Numbness in Arms/Hands
Neck Pain/ Stiffness	Loss of Smell	Cold Hands/Feet
Back Pain/ Stiffness	Period Pain	Cold Sweats
Fatigue	Constipation/ Diarrhoea	Dizziness
Depression	Fainting	Sleeping difficulty
Fever	Chest pain	Can't fight infections

Please indicate pain areas

Which of the above is the main reason you have consulted this practice: _____

What was the cause: _____

When did the problem commence: _____

Is the problem: Getting Worse Staying the Same Getting Better

Have you had a similar case before: Yes No

Does it interfere with: Sport Home Sleep Recreation Work

Have you previously seen a naturopath or acupuncturist:

Yes (Who) _____ Date:_____

No

If yes was it for a similar condition:

Yes

No

Have you seen any other health professional about this problem:

Yes (Who) _____ Date: _____

No

Exercise/ Sports Activities

Please outline any exercises or sports that you are currently participating in:

_____

_____

_____

_____

Is there anything else you would like to tell us:

_____

_____

_____

_____