

Twyla Martin R.Ac. TCM

Edmonton, AB (780) 908-6123

www.floweringbodymindspirit.com

Informed Consent Please Read Carefully

Informed Consent for Acupuncture & Herbal Care

I hereby request and give consent to the performance of Chinese Medicine including Acupuncture, Herbal Medicine and other related modalities within the scope of practice of Traditional Chinese Medicine Practitioners and Registered Acupuncturists in Alberta performed by Twyla Martin, R.Ac. (R1200267).

I have had the opportunity to discuss with the Twyla the nature and purpose of Acupuncture and Herbal Medicine care as well as any related procedures. I understand that results are not guaranteed as with all health care models.

I understand and am informed that, as with all health care, while rare, there may be some risks to treatment, including:

- With Acupuncture, although needles are pre-sterilized and disposable, temporary soreness, bruising, blistering, nausea, fainting, bleeding, infection and shock.
- With medicinal herbs, risk of reactions to treatment including nausea, vomiting, dizziness, headaches, malaise or general worsening of symptoms.

I also understand that transitions in healing (known as healing crisis) may also produce temporary periods of discomforts including:

- Emotional upset, fatigue, malaise, headaches, dizziness, rash or breakouts, nausea, vomiting or general worsening of symptoms.

I do not expect the Acupuncturist to be able to anticipate and explain all complications and do rely on the Acupuncturist to exercise judgment during the course of the procedures which she feels are in my best interest.

I have read the above consent, and have had opportunity to ask questions about its content. By signing below I agree to treatment offered or recommended by my acupuncturist. I intend this consent to cover the entire course of treatment, my present condition and any future condition(s) for which I seek treatment.

Dated this _____ day of _____, 20 ____ .

signature

Name:
(please print)

patient or parent/legal guardian signature

Name:
(please print)

Cancellation Policy

Life happens. You may find you have to miss, reschedule or cancel an appointment at some time. I request 24 hours notice **made by phone** to provide opportunity for your space to be filled. With less than 24 hours notice, FULL Service Fees will be otherwise applied as filling your spot on last minute notice is challenging.

Because technology is not always reliable email cancellation or texting will not be accepted as notice. **Phone calls ONLY please.**

Cancellation Agreement

I understand that I am responsible for payment in full for appointments that are missed without 24 hours notice (1 business day).

I have read and agree to the above policies.

Date: _____

Name: _____

Signature: _____

Privacy policy

All personal information is kept private and confidential.

We do not share any personal information with other organizations or individuals.

Your Credit Card will be kept on file and never be charged unless a missed appointment necessitates in which case you will be notified.

PATIENT CONSULTATION FORM

Section 8(1) of Alberta’s Acupuncture Regulation stipulates that an acupuncturist shall not undertake the care and treatment of a person unless

- (a) that person has already consulted with a physician or, in the case of dental pathology, a dentist about the condition for which care and treatment from the acupuncturist is being sought;*
- (b) that person has informed the acupuncturist that a physician or dentist has been consulted about the condition; and*
- (c) the acupuncturist has completed a patient consultation form.*

NAME OF ACUPUNCTURIST: Twyla Martin (R1200267)

OFFICE/BUSINESS ADDRESS:
10157-122 Street
Edmonton, AB T5N 3V9
(Pure Potential Fitness)

NAME OF PATIENT: _____

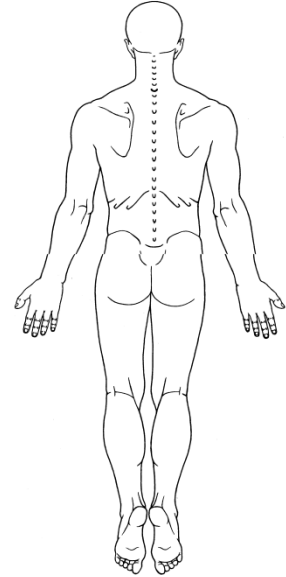
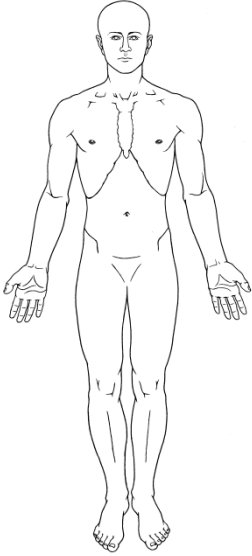
DATE OF CONSULTATION WITH ACUPUNCTURIST: _____

HAS THE PATIENT CONSULTED WITH A PHYSICIAN OR DENTIST (AS APPROPRIATE) ABOUT THE CONDITION FOR WHICH ACUPUNCUTRE TREATMENT IS NOW BEING SOUGHT?

YES _____ NO _____

**Please circle the location of your symptoms on the body outline below.
Rate the severity of the discomfort by circling a number on the scale between 0 and 10.**

Ache	Burning	Numbness	Pins and Needles	Stabbing	Stiff and Tight
OOOO	BBBB	XXXX	++++	/////	2222
OOOO	BBBB	XXXX	++++	/////	2222



No Discomfort 0 1 2 3 4 5 6 7 8 9 10 Intolerable Pain

**Please mark symptoms you currently experience 1 for mild, 2 for moderate and 3 for severe.
Circle those that have bothered you in the past and indicate 1, 2 or 3.**

General Symptoms <input type="checkbox"/> Headache <input type="checkbox"/> Fever or hot flashes <input type="checkbox"/> Chills/Sweating <input type="checkbox"/> Body Odor/excess perspiration <input type="checkbox"/> Clammy or cold feet/hands <input type="checkbox"/> Burning hands/feet <input type="checkbox"/> Fainting <input type="checkbox"/> Dizziness <input type="checkbox"/> Tremor	<input type="checkbox"/> Pain <input type="checkbox"/> Spasm <input type="checkbox"/> Cramp <input type="checkbox"/> Numbness <input type="checkbox"/> Easy Bruising/Bleeding <input type="checkbox"/> Weight Loss/ Gain <input type="checkbox"/> Ear Aches/Ringing <input type="checkbox"/> Rash/Hives <input type="checkbox"/> Edema	
Skin <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Fungal Infection <input type="checkbox"/> Bumps on outer arms or thighs <input type="checkbox"/> Itch	<input type="checkbox"/> Acne <input type="checkbox"/> Warts <input type="checkbox"/> Oily <input type="checkbox"/> Dry <input type="checkbox"/> Flakey <input type="checkbox"/> Stretch Marks – Source _____ <input type="checkbox"/> Depigmented Skin <input type="checkbox"/> Poor Wound Healing <input type="checkbox"/> History of Boils	
Respiratory & Circulation <input type="checkbox"/> Coughing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Recurrent Bronchitis/Pneumonia <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Dryness	<input type="checkbox"/> Sinus problems <input type="checkbox"/> Frequent Colds/Flu <input type="checkbox"/> Allergies <input type="checkbox"/> Fullness of Chest <input type="checkbox"/> Phlegm <input type="checkbox"/> Asthma	
Cardiovascular System <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Pulse/Heartbeat <input type="checkbox"/> Rapid Pulse/Heartbeat	<input type="checkbox"/> Poor Circulation <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Tingling in extremities <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pain in arms or legs <input type="checkbox"/> Angina <input type="checkbox"/> Palpitations <input type="checkbox"/> Feet or ankle swelling

Gastrointestinal System <input type="checkbox"/> Bloating <input type="checkbox"/> Distention <input type="checkbox"/> Pain/Cramping <input type="checkbox"/> Borborygmus (gurgling) <input type="checkbox"/> Diabetes (Type I or II) <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Indigestion <input type="checkbox"/> Ulcers <input type="checkbox"/> Rectal Itch <input type="checkbox"/> Jaundice	<input type="checkbox"/> Gas <input type="checkbox"/> Belching/Burping <input type="checkbox"/> Acid Reflux/Regurgitation <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea Indicate frequency of Bowel Movement _____	
Emotional Quality <input type="checkbox"/> Nervousness <input type="checkbox"/> Irritability <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Mood Swings <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Manic Tendencies	<input type="checkbox"/> Stress <input type="checkbox"/> Easy to Cry <input type="checkbox"/> Fear <input type="checkbox"/> Worry <input type="checkbox"/> Anger Easily <input type="checkbox"/> Restlessness/Fidgety <input type="checkbox"/> Feel Rundown <input type="checkbox"/> Rage <input type="checkbox"/> Exhaustion	
Muscles and Joints <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Swollen Joints <input type="checkbox"/> Foot Trouble <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Elbow/Wrist Pain <input type="checkbox"/> Hip/Knee Pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Other _____	Sleep Quality & Energy <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Night Sweating <input type="checkbox"/> Vivid/Excessive Dreaming <input type="checkbox"/> Mind Racing <input type="checkbox"/> Fatigue <input type="checkbox"/> Lethargy <input type="checkbox"/> Hours of Sleep per Day	
For Women Only Age of Onset of first Cycle ____ Menstruation length ____ days Cycle Length ____ days <input type="checkbox"/> Painful Menstruation <input type="checkbox"/> Excessive Flow <input type="checkbox"/> Irregular or Absent Cycle <input type="checkbox"/> Clotting <input type="checkbox"/> Cramps <input type="checkbox"/> Backache <input type="checkbox"/> Breast Pain	<input type="checkbox"/> Breast Lump <input type="checkbox"/> Emotional Upset <input type="checkbox"/> Vaginal Discharge/dryness (circle) <input type="checkbox"/> Yeast Infections/vaginal itch <input type="checkbox"/> Menopause <input type="checkbox"/> Menopausal Problems(please list) <input type="checkbox"/> Pregnancies (#) <input type="checkbox"/> Children (#) <input type="checkbox"/> Difficult Pregnancy <input type="checkbox"/> Difficult Labor/Delivery <input type="checkbox"/> STD _____	Last Period _____ Please describe your flow and colour: <input type="checkbox"/> Low/Loss of Sex Drive
Men Only <input type="checkbox"/> Testicular Swelling/Pain <input type="checkbox"/> Impotence <input type="checkbox"/> Infertility <input type="checkbox"/> STD <input type="checkbox"/> Prostrate Problems <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Retention of Urine <input type="checkbox"/> Trouble with ejaculation <input type="checkbox"/> Low/Loss of Sex Drive <input type="checkbox"/> Andropause	Genitourinary <input type="checkbox"/> Urination Problems <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Frequent Bladder Infections <input type="checkbox"/> Bad Odor <input type="checkbox"/> Burning/Painful Urination <input type="checkbox"/> Cloudy <input type="checkbox"/> Bloody <input type="checkbox"/> Any degree of renal failure <input type="checkbox"/> Kidney Stones	How often do you pee: _____ times a day _____ times at night
Exercise		
Hobbies & Relaxation		
Please Attach 3 day Menu. Or list here. 		