POINT OF ORIGIN

Dr. Debbie Smith

Maximum results wil be gained if patients follow the protocols, diets, supplemenation and treatment (including freqeuncy) prescribed.

PATIENTS INFORMATION

SURNAME _____ Sex M F □

FIRST NAME'S) _____

Number of Children _____ ID Number: _____

Date of Birth _____ Occupation: _____

Physical Address _____

Postal Address _____

Contact Number: Home: _____ Work: _____ Cell: _____

Email Address: _____ - you will receive reminders, appointment notifications and practice newsletters via email

PARENT'S DETAILS IN THE CASE OF THE PATIENT BEING UNDER AGE

SURNAME _____ FIRST NAMES _____

Contact Number: Home: _____ Work: _____ Cell: _____

Email Address: _____

MEDICAL AID DETAILS

Name: _____ Member Number: _____

Main Member: _____

REFERED BY:

Dr Debbie Smith is a registered Doctor of Homoeopathy, Acupuncturist and Doctor of Chinese Medicine.

All invoices including medication must be paid in full after each consultation. If payment is not received for whatever reason, the full amount plus any additional costs incurred in an attempt to receive the outstanding money, will be for the patients account.

Appointments not cancelled within 6 hours will be charged for in full. (Courtesy emails reminders are sent, but it remains the patients responsibility to keep the appointment)

Date: _____ Signature: _____

P.T.O

All information provided is managed in the strictest confidence.

Reasons for this consultation (Please be absolutely specific). When did it start

Specify other Ailments

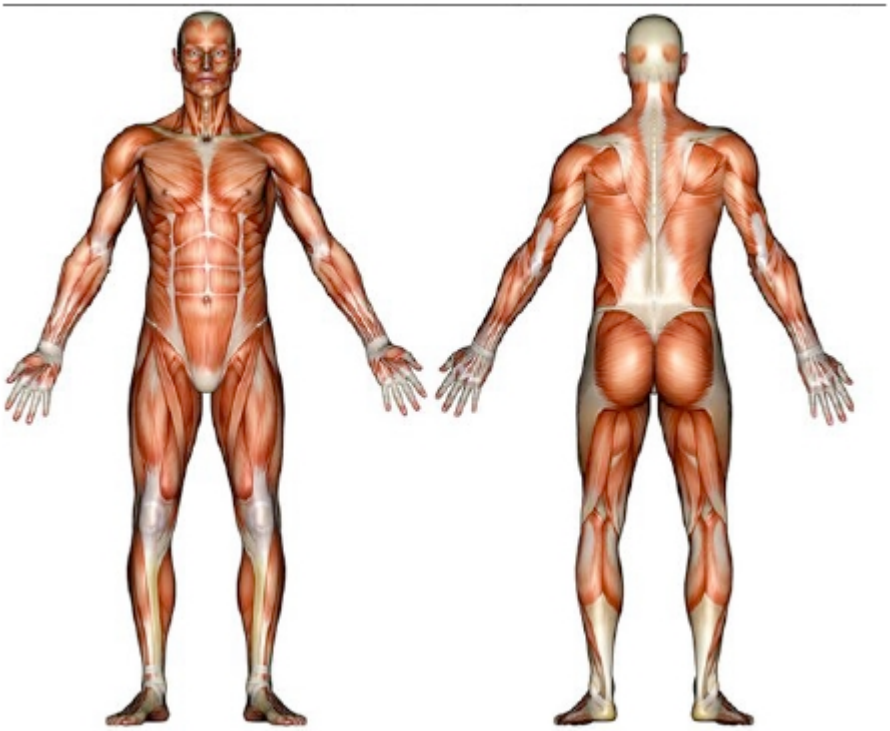
List operations and dates

PLEASE DO NOT DISCONTINUE THE USE OF ANY MEDICATION UNLESS SPECIFICALLY ADVISED TO DO SO

List ALL medication, vitamins or mineral supplementation including brand, remedies you are taking and the reasons for doing so:

Product	Reason	Duration

Please indicate on the sketch with an X where you are experiencing problems



POINT OF ORIGIN

Dr. Debbie Smith

Informed consent and terms and conditions

This constitutes a legally binding agreement between Dr Debbie Smith (Registration No: A7217) AND

Name: _____ ID nr _____

This agreement is made up of two parts, the first pertaining to Informed Consent, and the second pertaining to the Terms and Conditions of Treatment. You are asked to read each section carefully, in that by affixing your signature hereto you confirm that you have understood and agreed to these terms and conditions.

Informed consent

1.1 I the undersigned acknowledge and understand, that I have a legal duty to fully inform Dr Debbie Smith of any and all relevant medical information, which may be pertinent to my consultation with her. This shall includes (but not be limited to) information pertaining to any diagnosis, current treatment, or medical condition of whish I am aware, or are currently receiving treatment or care for by a registered health care professional.

1.2 I confirm that the purpose and nature of therapy and or advice, together with the benefits, risks, if any, associated with such advice have been fully explained to me, and that I have been afforded the opportunity to ask any questions pertaining to such.

1.3 I further confirm that I am responsible for the manner in which I utilise the information given to me, and that where necessary I shall consult with my treating health care professional as and when advised to do so.

1.4 Acupuncture consent form. “Acupuncture” means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body. Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations). The potential risks: slight pain or discomfort at the site of needle insertion, infection, bruises, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment. The potential benefits: acupuncture may allow for the painless relief of one’s symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem. “With this knowledge, I voluntarily consent to the above procedures

Signature:_____ Date: _____

Terms and conditions

Privacy

2.1 I understand that in accordance with section 14 of the National Health Act, 2003, I have the right to medical privacy and confidentiality, and that such information may not be disclosed to any party without my written authorisation.

2.2 In accordance with paragraph 2.1 above, I hereby provide written authorisation to Dr Debbie Smith to disclose any information to my treating health care practitioner, medical scheme or insurer (where applicable), which shall include any information pertaining to my consultation, nutritional advice and related matters,

Payment of fees

3.1 I acknowledge that notwithstanding any membership of any medical shceme, I am personally responsible for the payment of any and all amounts by Dr Debbie Smith for her services rendered. Fruthermore, in the event that I claim for my medical scheme or insurer, and for whatever reason either fails to pay, or pays only in part any amount owerd to Dr Debbie Smith, I shall be responsible for that amount or part thereof, in my personal capacity.

3.2 I understand that it is my sole responsibility to submit claims to my medical scheme or insurer, and that Dr Debbie Smith assumes no responsibility or liability in this regard.

3.3. I confirm that I have had all the costs associated with Dr Debbie Smith services explained to me, and that I have agreed to those charges.

3.4 In the event that I fail to pay any amount to Dr Debbie Smith, and cost are incurred in the recovery thereof, and then I shall be liable for those costs, including (but not limited to) any legal fees (at attorney own client scale), tracing fees and other related costs associated therewith.

Disclaimer

4.1 I confirm that the advice of Dr Debbie Smith makes no warrantly or claim to cure or treat any specific medical condition.

Warranty:

5.1 I hereby warranty that prior to beginning any health program that I will consult with my treating practitioner, and where necessary, ensure that he or she is all times informed.

5.2 In the event that I sign this Agreement on behalf of any minor, I warrant that I am authorised to act on his or her behalf, and that I am legally entitled to make informed decisions pertaining to his or her health.

5.3 Cancellation Policy: Please notify us of any change or cancellation of your appointment as soon as possible in order to accommodate other patients. A full consult fee will apply for notice of less than 6 working hours or for failing to attend appointment.

5.4 Regarding Appointment Times: In order to fully benefit from your treatment, please arrive at least a few minutes prior to your appointment time. In the case that you are late, your treatment will be shortened so that we may keep on schedule for our next patients.

General

6.1 Blood Test results: Where appropraite Dr Smith will email or SMS results if interpreted to be normal. Out of range pathology results will require a follow up appointment to be scheduled.

6.2 Returned Medication: According to the Medical Control Council no medications are returnable under no circumstances.

By signing this document you legally bind yourself to the terms and conditions contained herein.

Thank you for your understanding and cooperation.

Signature:_____ Date: _____

FEE STRUCTURE AND CONDITIONS 2017

Point of origin - Dr Debbie Smith and Dr Sandra Squara

Consultations

Rates below do not include medication	Duration	Fee per Consult
Initial Consult (Patients that have not visited the practice for 2 years will be consdiered new) See Special fees for muscle treatments	45 min	R830
Follow up consult	30min	R570
Returning patient (If no consultation for 2 years then please book initial - complete all new documentaiton)		
Short appointment follow up (Please indicate when you make an appointmnet if you need a short appointment, otherwise standard half hour appointments will be booked and charged accordingly)	15 min	330
Child Initial Consult (Younger than 10yrs)	30min	570
Child Follow Up Consult	30min	450
Telephone / Skype Consult (Non-Claimable) / Emails that take 15 minutes to answer	15 min	350

Special Fees

Muscuoloskeletal and sport injury (new appointments)		R650
Follow up Acupuncture treatments Packages - This is to assist patients that will require multiple treatments. Does not include initial consultation.		
5 Treatments (Use within 6 weeks)	20% saving	R2,280
10 Treatments (Use within 10 weeks)	30% saving	R3,990
Terms and conditions for packages. Must be paid upfront. The treatments will be included for the original complaint. Appointments must be used as follow 5 treatments : 6 week period, 10 treatments 10 week period (No exceptions). Bookings as per person and can't be transfered to another person		
Family package - Book an acupuncture appointment with a family member for the same time and enjoy a 20% discount on both appointments		R456 each

A limited number of "unlimited visits" appointments are available. Enquire at reception for more information.

Other treatments

Lymphatic drainage	R220 per session
Lymphatic drainage package (Book and pay all 10 appointments and receive 2 at no cost)	R1760 (20% saving)
Facial rejuvenation acupuncture - Includes a pretreatment gel and post serum treatment to enhance collagen and reduce fine lines)	R600 per session
Facial rejuvenation acupuncture - prepay for 10 treatments and receive 2 at no cost. Best results to have 10 treatments within 2 months.	R4800 (20% saving)
Myofascial release (Included in acupuncture treatments if needed)	R250 - 10 minute session
Bioptron Light - for treating inflammation, skin problems, scars, acne, joint problems, sprains, arthritis, sinus probles. (Included in acupuncture treatments if needed)	R280 per 20 minutes

Missed appointments or appointments not cancelled telephonically within 6 working hours will be invoiced in full

All fees are inclusive of 14% VAT

Patients signature: _____ Date: _____

By signing you accpet all fees and conditions described

Timeline of your diseases,significant events in your life

Please complete in chronological date order any conditions that you have had in your life. Think about surgeries, doctor visits, hospital visits, emotional trauma and stress. Anything that had an impact on your life. Even if you never have been well since a cold / flu etc. Approximate time is suitable Oct 2009 or just the year if you are not sure

Date (approx)	Problem

HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

☐ Past month (New Patient) ☐ Past week (Follow-Up) ☐ Past 48 hours (Acute)

If you are a new patient then complete the questionnaire with the past month duration – **PLEASE ADD SCORES WHEN COMPLETE**

Point Scale: 0 – *Never or almost never* have the symptom. **1 –** *Occasionally* have it, effect in *not severe.* **2 –** *occasionally* have it, effect is *Severe.* **3 –** *Frequently* have it, effect is *not severe* **4 –** *Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD _____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL** _____

EYES _____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS _____ Itchy Ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
TOTAL _____

NOSE _____ Stuffy Nose
_____ Sinus problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
TOTAL _____

MOUTH/ THROAT _____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of invoice
_____ Swollen or discoloured tongue, gums, lips
_____ Canker Sores **TOTAL** _____

DIGESTIVE TRACK _____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
TOTAL _____

JOINTS/ MUSCLE _____ Pains or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pains or aches in muscles
TOTAL _____

WEIGHT _____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating
TOTAL _____

ENERGY/ ACTIVITY _____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

SKIN _____ Acne

_____ Hives, rashes, dry skin

_____ Hair Loss

_____ Flushing, hot flashes

_____ Excessive sweating **TOTAL** _____

HEART _____ Chest Pain

_____ Irregular or skipped heart beat

_____ Rapid or pounding heartbeat

TOTAL _____

LUNGS _____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing **TOTAL** _____

MIND _____ Poor Memory

_____ Confusion, poor concentration

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ Poor concentration

_____ Poor physical coordination

TOTAL _____

EMOTIONS _____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression **TOTAL** _____

OTHER _____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

TOTAL _____

GRAND TOTAL **TOTAL** _____

Please add up scores for each section when done.

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑–

PAP ❑ + ❑–

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: cups/d _____

Tea: cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)