POINT OF ORIGIN

PATIENT'S 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 Name's_____

Contact Number Home_____ Work_____ Cell_____

Email Address _____

MEDICAL AID DETAILS

Name _____ Member Number_____

Main Member _____

REFERED BY: _____

Dr Sandra Squara is a registered Doctor of Homoeopathy, trained in Functional Medicine, Integrative Medicine, Acupuncture and Functional Nutrition.

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 patient's responsibility to keep the appointment).

Name _____ Member Number_____

All information provided is managed in the strictest confidence.

P.T.O

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

Specify other Ailments:

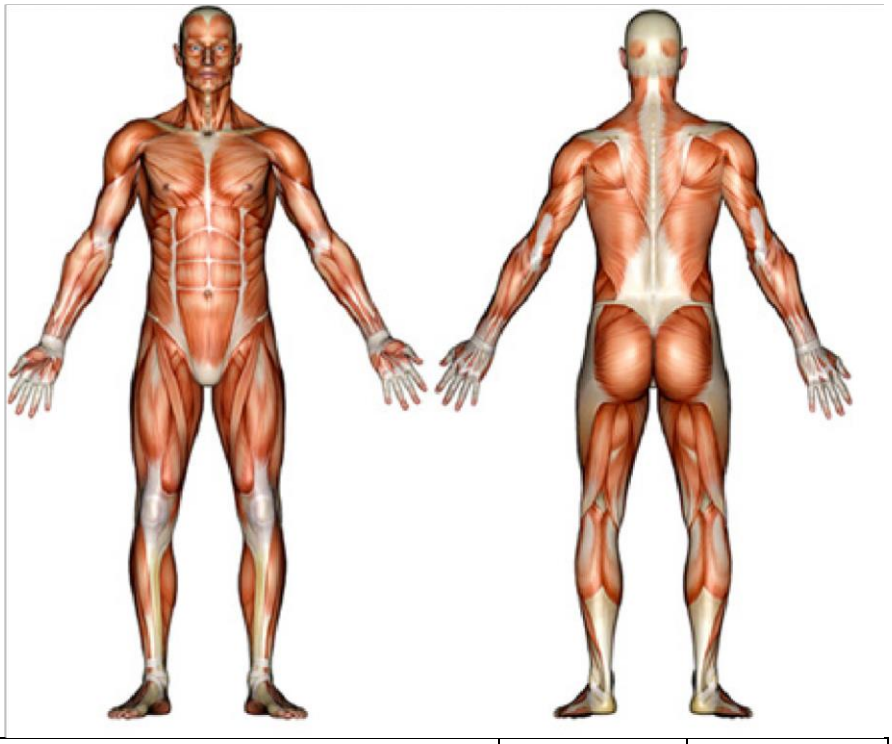
List operations and dates:

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

List ALL medication, vitamins or mineral supplementation, 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.



FEE STRUCTURE AND CONDITIONS 2017 **Consults**
Rates below do not include medication

	Duration	Fee Per Consult
Initial Consult	60min	R830
Follow Up Consult	45min	R570
Returning patient (If no consult after 2 years)	30min	R830
Follow Up (short appointment) (Please indicate when you make an appointment if you need a short appointment, otherwise standard half hour appointments will be booked and charged accordingly)	15min	R330
Acupuncture	20 min	R570
Telephone Consult (Non Claimable)	15min	R350

INFORMED CONSENT AND TERMS AND CONDITIONS

This constitutes a legally binding agreement between Dr Sandra Squara (Registration No: A07476) AND

Name: _____ ID no _____

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 Sandra Squara of any and all relevant medical information, which may be pertinent to my consultation with her. This shall include (but not be limited to) information pertaining to any diagnosis, current treatment, or medical condition of wish 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, Dr Squara uses the Dry Needling Technique. 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. 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 Sandra Squara 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 scheme, I am personally responsible for the payment of any and all amounts by Dr Sandra Squara for her services rendered. Furthermore, 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 owed to Dr Sandra Squara, 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 Sandra Squara assumes no responsibility or liability in this regard.

3.3. I confirm that I have had all the costs associated with Dr Sandra Squara 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 Sandra Squara makes no warranty 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 appropriate Dr Sandra Squara 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: By law no medication is returnable.

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

Thank you for your understanding and cooperation.

Signature: _____ Date: _____

DETOXIFICATION QUESTIONAIRE

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

_____ Diarrhoea

_____ 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

_____

Please add up scores for each section when done.

GRAND TOTAL:_____

HEALTH HISTORY

Name _____Date of Birth _____ today's Date _____

Occupation _____Age _____ Height _____ Height _____ Weight _____ Desired weight _____

Marital Status: ☐Single ☐Partner ☐Married ☐Separated ☐Divorced ☐Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began: _____

_____

_____ Date

of last physical exam _____

Practitioner name and phone number_____ Laboratory

procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

_____ Outcome _____

What types of therapy have you tried for this problem(s)?

☐ Diet modification ☐fasting ☐vitamins/minerals ☐herbs ☐ homeopathy ☐chiropractic ☐acupuncture ☐conventional drugs

☐other _____

List current health problems for which you are being treated: _____

_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right your weight today _____

Have you had an unintentional weight loss or gain of 5kg or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, and solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

☐Corrective lenses ☐Dentures ☐Hearing aid ☐Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ☐see ☐hear ☐taste ☐smell ☐feel hot/cold sensations

☐ Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers) Strong

like for any of the following flavors: ☐sour ☐bitter ☐sweet ☐rich/fatty ☐spicy/pungent ☐salty

Strong dislike for any one of the following flavors: ☐sour ☐bitter ☐sweet ☐rich/fatty ☐spicy/pungent ☐salty

Do you: ☐Prefer warmth (i.e., food, drinks, weather, etc.) ☐Prefer cold (i.e., food, drinks, weather, etc.) ☐No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:	Time of day you feel the worst or your symptoms are aggravated:
☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐11 a.m. - 1 p.m.	☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.	☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.	☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.	☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhoea	☐ Low grade fever	☐ Itching/rash Insert

Any other important information here:

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 men- strual 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, antihistamines, 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 dis- ease tendencies (e.g., cancer, heart disease, etc.)