



NYINDA CLINIC ཉི་ལྷོ་སྐབ་ཁང་ Tibetan Medicine &

Holistic Healing Intake Form~ Consults & Kunye Therapeutics

Medical History is confidential, though may be shared with primary care physician or specialist with permission

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ e-mail _____

Home Phone _____ Cell Phone _____

Primary Care Physician Name and Phone: _____

Referred by: _____

For Kunye Tibetan Massage - what level of pressure do you prefer?

***Light *Medium *Deep**

Do you have an allergies or sensitivity to oils or scents?

Are there limitations to your movements, muscle injury or any issues that I should be aware of before you receive bodywork?

Major Complaint: What is your primary reason/s for coming for Tibetan Medicine?

Are there times, seasons or things which aggravate your symptoms?

Are there things which help your symptoms?

Over →

Personal History:

Please check all conditions you currently have or have had in the past: **C for current P for Past**

- | | |
|---|--|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Antibiotic Use | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Bleeding Easily | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Pertussis / Whooping Cough |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Psoriasis / Eczema |
| <input type="checkbox"/> Celiacs Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cognitive Focus Difficulty | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Issues |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stools - Constipation / Loose |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vascular Disease / Circulation Issues |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Vitamin Deficiency |
| <input type="checkbox"/> Hepatitis | Other _____ |

Family History:

Please check all that apply and who: **F-father, M-mother, PG- or MG-p/m-grandparent, S-sibling, C-child**

- | | |
|---|--|
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Herpes |
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| <input type="checkbox"/> Hepatitis | Other _____ |

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Current Medications & Supplements: (Please list or attach list all you are taking)

List any surgeries, serious illness, broken bones, injuries, hospitalizations etc.

Allergies: Are you allergic or hypersensitive to any:

Drugs: _____

Foods: _____

Other: _____

Are there any Lab / medical tests that your GP or specialist is tracking regularly?
Cholesterol, Hepatitis, IGG, Mammography, Pap, PSA, Stool?

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Nyinda Clinic: Tibetan Medicine & Holistic Healing Policies

We request a 36 hrs advance notice for cancellations of appointments or you are held responsible for full payment. *Snow / severe weather late cancellation fees for under 24 hrs is up to the discretion of the practitioner. Please plan ahead for winter weather! We can be flexible with weather, but if we come and you don't, without proper notice, you'll be charged fees.*

All payments due when service is rendered. We accept Check, Cash, Venmo & travelers checks. Currently we do not take cards. *We can take a card in rare circumstances, but the 3.88% use fee is added to your total.* If there are financial hardships, please discuss this before the appointment. Student discounts applies only to those currently enrolled in half or 3/4 time classes.

Payments past 30 days of the invoice or mailed service are billed a \$20 late fee. Additional \$10 fees are added each 30 days. Returned checks have a \$40 fee for processing and bank charges.

It is advised to make a list of questions between consults. Phone / email consults for follow ups or for of town clients are charged consultation fees. Research and multiple long inquiries are charged in quarter hour sections for time taken for written responses.

We are not available or responsible for being 'on call' for frequent or detailed phone calls, or emailed questions. Frequent questions constitute charges for replies and recommendations if you seek consult. You will be billed accordingly in the quarter hour system for out of office contact based on the practitioner's discretion. **WE DO NOT HAVE TEXT MESSAGE CAPACITY**

We will do our best to get you an appointment at your earliest opportunity, but cannot guarantee to get you in immediately. *If you have a medical emergency call your licensed medical care provider.* Please plan ahead when making follow up appointments as our schedule is limited.

Separate appointments are made for Kunye Massage & External Therapies and Pulse / Urine Diagnostic Consults unless the practitioner requests otherwise. We are unavailable to check your pulse and urine without an additional fees when coming for external treatments; due to time constraints and in fairness for diagnostic appointments.

We respectfully ask you to be on time for your appointments. If late, we may be unable to give you the full time for your appointment. Please cover questions regarding your next appointment or other issues during your time, or request a email follow up consult billed in quarter our segments. If we fall behind with the person in front of you, please have patience. We do our best to make that time up to you. We cannot however always make up time from your tardiness.

Long term refills of Tibetan supplements require re-check either by a TMD or those deemed qualified to assess you according to the Tibetan System. **Refills are given only 2 times, seasonally, or for a 6 months maximum based on the TMD's discretion before consult is required.**

These policies are outlined in both in this Policy Form & Informed Consent. By signing this policy form at the initial consult, bodywork or massage, you agree to the clinic's policies and procedures regarding appointments, scheduling, phone calls, texts and payments.

Signature _____ **Date** _____

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Informed Consent: Tibetan Medicine Consults, Kunye Therapeutics, Jin Shin & Acupressure

I, (*PRINT NAME*) _____ hereby state that it is my choice freely given for seeking traditional Tibetan Medicine treatment. I have had the opportunity to ask any questions about the history of the Tibetan Medical tradition, its modes of traditional treatment, and my practitioners qualifications prior to the commencement of any consultation.

I have been informed that Tibetan Medicine is not recognized, nor licensed in the USA. Its treatments are considered alternative and are *not a replacement for traditional qualified licensed medical care or care of a licensed psychologist*. I agree that the practitioner of Tibetan Medicine, or *Menpa TMD*, though recognized in other countries as a doctor is NOT recognized as such in the USA and *therefore cannot legally diagnose, prevent, prescribe, treat or cure any diseases*.

I understand that the traditional Tibetan Medical System employs asking questions about ones diet, lifestyle and emotional state. The practitioner may suggest dietary and lifestyle changes. Traditional dietary supplements may be suggested, though are not required to assist diet and lifestyle changes. These are made in the traditional manner and may not be recognized by the FDA. I also have been informed that the traditional Tibetan Medical System can include massage, moxibustion, compress therapy, acupuncture and the draining of bad blood techniques. If any of these external therapies should be suggested by my practitioner, I understand I have the choice to accept such methods or decline them prior to commencement of such modalities.

I have been informed that my Tibetan Medical practitioner may request release forms in order to obtain necessary medical histories or test results from my primary care physician or specialist. I understand I have the right to decline all such requests but that my practitioner prefers an open dialogue with other practitioners or doctors. It has been explained that my practitioner will take any calls from my licensed medical doctor or any other therapists I am working with if they request or require information on the methods employed in traditional Tibetan Medicine as they pertain to my case. Any requests which require lengthy time or translations from my practitioner will come with costs billed in quarter hour segments with such costs incurred by myself.

I understand my practitioner isn't available or responsible for being "on call" for detailed phone calls or emails. I have been informed they DO NOT receive text messages. I understand I will be billed accordingly for frequent out of office contact based on my practitioner's discretion as further outlined in the clinic policies.

I also have agreed to the information from my consultations with my Tibetan Medical practitioner to be documented and kept by them; with the understanding that they are private just as is practiced under basic medical confidentiality. However, I agree that if any part of my consultation or history is published for research, presentation or case study that ALL identifying personal information will be left out.

I agree to take full responsibility for my choice of consulting with the Tibetan medicine practitioner having fully read the above statements and having been given an opportunity to ask any questions and have had them answered to my satisfaction.

I understand and agree to the policy that I must give 36 hrs advance notice for cancellation of any appointments or I may be held responsible for payment. I understand that payment is due when services are rendered.

Signed _____ Date _____

Parent if under 18 yrs of age - Print and Sign Name

Witnessed by _____ Date _____

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