The address of your consultation is:
Park Shopping Center, Prussia Street, Stoneybatter. D07NC56.

The entrance is on the left side of the Park Shopping Centre. Plz, press any bell once you get there or ring my mobile 0871625566

If you have to cancel your appointment, please do it before 48hrs, otherwise a fee of 60€ is applied.

The first Acupuncture consultation is more detailed and costs 70€, the following ones 65€.
The nutrition consultation costs 150€.

It is accepted payment by Bank Transfer. The Clinic DOES NOT accept payment with cards
The details of the Bank Account for payment is:
Fernanda Solano
IBAN: IE30 BOFI 90087760 303572
BIC: BOFIIE2D

Plz bring shorts to use during the session.
Eat a light meal before your appointment

Name:
Email:
phone:
Date of birth:
Height:
Name of your GP

1) Main reason for looking for acupuncture/ nutrition?
2) How this condition affect you?
3) How long have you had this condition?
4) Put an X by the symptoms that you have now and a star (*) next to the ones you have noticed within the last 3 months

Anxiety
Insomnia
Catches cold easily or frequently
Cold feet and/or hands
Difficult to concentrate
Fatigue
Any digestion problem
Headaches
Allergies
Sinusitis
Dizziness

Tinnitus
Frequent urination at night

5) Do you currently have any infectious diseases?

6)Which emotion would you identify yourself with:
Anger
Entrapped/ Stuck in life
Overexcitement
Sadness
Grief
Worry/ Pensiveness.
Fright
Fear

5) Are you pregnant?
Method of birth control
Date of last menses

6) Stools and urination
How many times per day?
(stools) What is the consistency? Loose, hard?
(urination) What is the color?

7) Do you drink alcohol ? If yes, how many time per week?

8) Do you use any other drug (illegal or legal)?

9) Do you prefer hot or cold temperature?

10) Is there any other important thing would you like to share about your health?

11) Do you have a peacemaker?

12) How many times do you eat/drink per day?
Fruit
Vegetables
Grains (rice, beans, lentils, millet, barley, etc)
Meat

Milk and dairy
Bread and/or Pasta/ Pizza
Coffee
Soft drink/ energy drink
Chocolate/candy/biscuits
Water

Do you exercise? How many times per day?

Acupuncture Informed Consent To Treat

Acupuncture Consent Form

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation and nutritional counselling.

I have been informed that acupuncture is generally safe method of treatment, but that I may have some side effects, including bruising, numbness or tingling near the needles sites that may last a few days, and dizziness or fainting. I understand that while this document describes the major side effects, other risks and side effects may occur.

By voluntarily signing below, I intend this consent document to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

Patient Signature:

Date:

Fernanda Betti Solano

Acupuncturist

COVID 19 Form

I have been angering to social distancing guidelines
I have not been in contact with any confirmed or suspected Covid 19 cases.
I do not have Covid 19 symptoms
I have had no respiratory symptoms the last 7 days

I am not waiting for a Covid 19 test result
I will call and cancel my appointment if the above change

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person to person contact, in which Covid 19 can be transmitted.
I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting Covid 19 simply by being in a healthcare office.
I understand travel increases my risk of contracting and transmitting the Covid 19 virus. I verify that I have Not in the past 14 days I have not traveled.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

Name
Signature