

PLEASE READ AND SIGN THE CONSENT FORM IF YOU AGREE TO THE TERMS

Dr Bill Reeder - Consent Form

Please Read ENTIRE FORM

Surname	First Names
Preferred first name	DOB

To get the best outcome from your Consultation and Expectations

Dr Bill Reeder is a registered medical doctor specialising in Integrative Medicine but is not practising as a General Practitioner (GP) i.e. providing regular GP services. You still require a GP.

Dr Reeder may suggest integrating non-mainstream options based on the premise that many complex, chronic conditions need to be managed by identifying, where possible, the underlying biochemical or physiological cause, then implementing biological (natural) corrective treatments where there are no better 'Standard of Care' or 'Mainstream' medical solutions.

Success cannot be guaranteed any more than SOC or standard drug treatments. Safety is of paramount importance.

'Standard of Care' treatments in certain conditions however may be the best and proven approach. In this case, you may be referred back to your own medical advisor(s).

By consulting with Dr Reeder it is understood that treatments may be non-mainstream and that you wish to explore these options. Such options are based on as much evidence, benefits and safety as possible. If you prefer mainstream ('Standard of Care') treatment, please indicate to Dr Reeder or staff prior to the consultation. You have the opportunity to discuss any treatments with other health providers, family or other trusted persons.

To comply with best practice, it is advisable that your doctor is informed about treatments from Dr Reeder. A summary will be supplied to you by email after the consultation - this is required by Medical Standards. You can take or send this to your GP at your discretion as it is your personal information.

Fees are based on time and will include any pre-consult review of your case notes, consultation itself, your summary, treatment plan. Should you have any queries regarding fees, please discuss with Dr Reeder or Jo (admin) prior to the consultation.

Fees Guide – based on time

Initial Consultation

\$425 (1 hour)

Includes, but is not limited to assessment, review health history, investigation of relevant health issues of concern, relevant lab investigations, recommendations moving forward (time permitting).

Shorter First or Follow Up Consultations

\$210 (30 minutes)

Follow up from initial consultation. Assess initial responses to treatments, identify and explain any test results and continue ongoing plan of management.

Short Consultations

Brief consultations and follow ups

\$85 - \$120 (5-15 minutes)

Cancellations: A \$50 fee is charged for no show – so please cancel **24 hours** before the appointment.

I have read and accept the conditions:

Signature:

Date:

Date today:

INTEGRATIVE MEDICAL CLINIC NEW ZEALAND -Dr Bill Reeder

Surname:		Please Attach Photo
First Names:		
DOB:		
Address:		
Phone Hm:		
Phone Mobile:		
Email:		
NHI:		
GP		
Spouse/ Partner		Spouse/ partner Phone:

List YOUR IMPORTANT Current and Past Medical History			
Date of onset	What is the diagnosis?	Condition active?	Or resolved?

List Important FAMILY Illnesses				
Father	Mother	Brothers	Sisters	Grandparents

Dental Health	Current Occupation:
Silver Amalgam Fillings?	
Any Root Canals?	Past Occupations:

Special tests or procedures			List Current Medications and supplements		
	✓	Year	Result		
Colonoscopy					
Gastroscopy					
MRI					
CT Scans					
Mammography					
Ultrasound					
ECG					
Angiogram					
Bone Density					
Hair Analysis					
X Rays					
Other special tests?					

Office Use Only	General Consent Form					

Please ✓ if you use or have:										
perfumes <input checked="" type="checkbox"/>	Use house cleaners <input type="checkbox"/>	drink from plastics <input type="checkbox"/>	new home <input type="checkbox"/>							
hair dyes <input type="checkbox"/>	use paints <input type="checkbox"/>	mould in home <input type="checkbox"/>	very old home <input type="checkbox"/>							
other body products <input type="checkbox"/>	weed, insect sprays <input type="checkbox"/>	mould in workplace <input type="checkbox"/>	Smoke – how many per day <input type="checkbox"/>							
recent vaccinations <input type="checkbox"/>	home pest products <input type="checkbox"/>	air conditioning <input type="checkbox"/>	work with chemicals <input type="checkbox"/>							
Are you especially sensitive to chemicals <input type="checkbox"/>	Are you now or have you been exposed to MOULD <input type="checkbox"/>	Please List any Vaccines and dates over the last 3 years. } <input type="checkbox"/>								
List any known exposure to chemical toxins, including MRI injection enhancers:										
List travel to other countries:										
Did you have any sickness:										
Please ✓ if you have (or had) significant exposure to Toxic Metals below:										
Lead <input type="checkbox"/>	Mercury <input type="checkbox"/>	Arsenic <input type="checkbox"/>	Cadmium <input type="checkbox"/>							
Other <input type="checkbox"/>										
Details:										
Lifestyle questions (Tick most applicable)										
My work is: <input type="checkbox"/> High Stress <input type="checkbox"/> Low Stress		Leisure Time: <input type="checkbox"/> A lot <input type="checkbox"/> Occasional <input type="checkbox"/> Never								
My home life is: <input type="checkbox"/> High Stress <input type="checkbox"/> Low Stress		Exercise: <input type="checkbox"/> A lot <input type="checkbox"/> Occasional <input type="checkbox"/> Never								
My diet is: <input type="checkbox"/> Excellent <input type="checkbox"/> Could be better <input type="checkbox"/> Poor										
My weight is: <input type="checkbox"/> Very good <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight										
Dental Health <input type="checkbox"/> Dental Amalgams <input type="checkbox"/> Root Filled Teeth <input type="checkbox"/> Jawbone Infection <input type="checkbox"/> Gums Infection										
General Quality of Life Assessment - QOL										
Tick the number that you think best represents you:										
	Very Bad			Average				Very Good		
Please rate	1	2	3	4	5	6	7	8	9	10
My overall health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy level overall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am in PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body Shape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel the heat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes									
Do you feel the cold	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes									

General Health Information

Please ✓ if you have:

Digestion System	✓		Brain and Nerve System	✓	
heartburn, reflux			anxiety		
bloating			depression		
wind			tinnitus (ear noise)		
abdominal pain			pins and needles		
constipation			numbness		
loose stools			vision problems		
blood in stools			hearing problems		
mucus in stools			poor memory		
irritable bowel			migraines		
mouth ulcers			headaches		
fatty foods reaction			restless legs		
sweet craving			dizziness		
change in bowel habit			vertigo		
intestinal infections			cramps		

LIST any known food intolerances/allergies:

Respiratory System	✓		Heart and Circulation	✓	
hay fever			Angina – heart pain		
sore throats			Other chest pains		
cough			poor circulation		
asthma			leg clots		
sinus trouble			blood disorder		
mucus in throat			anaemia		
chest infections			short of breath		
			palpitations of heart		
Immune System	✓		swelling of ankles		
skin infections			high blood pressure		
lot of sore throats, colds			low blood pressure		
bladder, kidney infections			Vein clots		
cold sores			Muscles, Joints	✓	
genital herpes HSV II			sore muscles		
thrush (candida)			very weak muscles		
tinea			losing muscle		
other infections?			pain in joints		
			swelling of joints		
Skin	✓		back or neck pain		
psoriasis			Mental health	✓	
dermatitis			feel depressed a lot		
eczema			feel loss of enjoyment		
rashes			memory getting bad		
poor nails			don't feel like living sometimes		
poor hair			can't concentrate now		
losing hair			poor motivation		
dry skin			wake up early		
excessive aging skin			avoid social contact more		

