Patient History Questionnaire

Title:____ Given Name:_______________ Family Name:_________________

Date of Birth:________ Sex: • F • M Occupation:____________

Address:______________________________Suburb________________Post code_______

Phone: (Mobile)_________________ (Home) _________________ (Work)__________________

Private Health Fund :______________ Membership Number:_______________

Email ______________________ Guardian :______________ Ph_________

1. Do you have any known Allergies or Alert notation?

   • No • Yes____(Please indicate)

2. Do you have a tendency to bleed or bruise easily? • No • Yes

3. Please indicate whether you have any of the following conditions?

   • H/L BP • Heart Prob • Cancer • Asthma • Diabetes • Epilepsy

   • Tuberculosis • Stroke • Skin Condition • HIV • Vertigo

   • Thrombosis/Circulatory Condition • Hepatitis • Stress • Migraines

   • Surgeries __________________

4. Please list any relevant family medical history

   ____

5. Please list your current medical conditions and medications:

   ____

6. Female Clients: Are you pregnant or is there a possibility of being pregnant? • No • Yes

7. Are you covered by Works Compensation?

   • No • Yes, Patient's Claim Number:__________________________

8. Are you a:

   • Pensioner • Student • Low-Income Healthcare Card Holder

9. How have you come to know our clinic?

   • Friends • Internet • Others ___________________

10. Would you like to receive our special promotion message via SMS or Email?

    • Yes • No

I understand by signing this form that the information provided is true to the best of my knowledge. Changes to the above should be advised upon future visits. I consent to receive proposed treatments by the attending practitioner subsequent to discussing the benefit of that to my health. I also understand that all bills are to be settled at the conclusion of each visit.

Signature:____________________________(Guardian if applicable)

Date: _________________