true health

PRIVATE AND CONFIDENTIAL

First Name:_____ Surname:_____

Address:_____ Suburb: _____ Postcode: _____

Telephone: (H):_____(W):_____(M):_____

Email:_____ Date of Birth:_____

Name of Private Health fund (if applicable):_____

Concession Card number (if applicable):_____ Expiry Date_____

Occupation:_____ Name of Family Dr:_____

Next of Kin: (Name)_____ Contact Number:_____

Please tick how you heard about us: ❑ Sign ❑ Yellow Pages ❑ Website ❑ Referral: (Who)_____

Recreational Activities:_____

Primary Complaint:_____

Please tick (✓) any of the following treatments that you have experienced before:

- ❑ Acupuncture
- ❑ Chinese Medicine
- ❑ Chiropractic
- ❑ Counselling
- ❑ Kinesiology
- ❑ Massage Therapy
- ❑ Naturopathy
- ❑ Osteopathy
- ❑ Physiotherapy
- ❑ Podiatry
- ❑ Reiki
- ❑ Reflexology

MEDICAL HISTORY: Please tick (✓) all appropriate boxes:

- ❑ Abdominal or digestive problems
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma or breathing conditions
- ❑ Blood clots
- ❑ Cancer / Tumours
- ❑ Depression / Anxiety
- ❑ Diabetes
- ❑ Fatigue / Tiredness
- ❑ Headache / Migraine
- ❑ Hearing problems
- ❑ Heart / circulatory problems
- ❑ Hernias
- ❑ High / Low blood pressure
- ❑ Infectious disease
- ❑ Menstrual problems
- ❑ Muscle / Bone injuries
- ❑ Muscle or joint pain
- ❑ Numbness or tingling
- ❑ Previous motor vehicle accident
- ❑ Rash / Athlete's Foot
- ❑ Seizures
- ❑ Sinus problems
- ❑ Skin condition
- ❑ Stroke
- ❑ Ulcer
- ❑ Urinary problems
- ❑ Varicose veins
- ❑ Vision problems

Are you pregnant? YES / NO If Yes, how many weeks?_____ Number of Children:_____

Previous surgery:_____

Current medications:
(Including aspirin, ibuprofen, herbs, vitamins etc):_____

_____

INFORMED CONSENT AND WAIVERS: Please tick (✓) if you consent and agree to the following:

- ❑ I understand that True Health does not hold accounts and that I am liable for all fees incurred at time of treatment
- ❑ I understand that 24hrs notice must be given when cancelling a booking or a cancellation fee may be charged
- ❑ I consent to True Health practitioners touching my body in order to conduct their job in a professional manner
- ❑ I consent to allowing True Health to record my image or voice for use in photographic, audio or video footage for use in promotional / educational purposes. I understand that I am able to revoke this permission at any time. I also understand that a full waiver may be presented for my review at any time.

Signature of patient or guardian:_____ Date:_____