TRUE HEALTH

PRIVATE & CONFIDENTIAL

NEW PATIENT FORM

PERSONAL DETAILS

First name: ______ Surname: ______

Address: ______

Suburb: ______ Postcode: ______

Phone (H): ______ Phone (W): ______

Mobile: ______ Date of birth: ______

Email: ______

Occupation: ______

Please tick how you heard about us:

- ☐ Website
- ☐ Yellow Pages
- ☐ Google
- ☐ Street signage
- ☐ Referral – who: ______

MEDICAL DETAILS

Name of private health fund (if applicable): ______

Concession card number (if applicable): ______ Expiry date: ______

Name of family doctor: ______

Emergency contact: ______ Phone: ______

Primary complaint: ______

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

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

FORM CONTINUED OVERLEAF >

MEDICAL HISTORY

Please list known medical issues:

Previous surgeries:

Known allergies:

Are you pregnant? ☐ No ☐ Yes – how many weeks?

Number of children:

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 24 hours 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 True Health practitioners confidentially sharing my health details with each other where necessary.
- ☐ 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.

Please print your name:

Signature:

Date: