Personal and Work Information

Please take the time to thoroughly complete the questionnaire. Mark anything you don't understand with a question mark.

Name: _____ Birth Date: _____
Age: _____ Sex: _____ Home Phone: _____ Mobile: _____
Address: _____ Suburb: _____
Postcode: _____ Email: _____
Emergency Contact: _____ Relationship: _____
Phone: _____ Occupation: _____
Marital Status: _____
How did you learn about this clinic: _____
Name of Doctor: _____ Phone: _____
Address: _____
Email: _____
Health Fund: _____

Cancellation Policy

In the event that you need to cancel your appointment, we require 24 hours notice to be given.

Consent Form and Agreement

While the chances of experiencing complications are small, it is a policy of this practice to inform each patient about them. These complications may include soreness, inflammation, dizziness, nausea and headaches. These issues may arise due to cleansing and detoxing of toxins and parasites from the body as a result of energetic movements of acupuncture, lymphatic drainage, dietary elimination of allergic and toxic foods and a general change towards a healthy lifestyle. Initially you may feel worse for a short period of time as your body adjusts to a possible elimination process. If you need to know more about this process, please ask your practitioner for more information. I have read and understand the above statements regarding these possible effects.

_____ _____ _____

Patient/Guardian Signature **Relationship** **Date**

Medical and Health History

Please list your health concern and the length of time you have known of these issues:

_____

_____

_____

_____

_____

Please list traumatic events in your life that you believe have impacted your health:

_____

_____

_____

Allergies (Food, drugs): _____ _____

_____

_____ _____

Current Medications: _____

_____

Current Supplements, herbs: _____

_____

Are you aware or do you suspect that you have been exposed to toxic substances in your home or work environment? Please describe: _____

_____

Childhood illnesses: _____

_____ _____

Immunizations: _____

_____

_____

Surgical Procedures: _____

_____

_____

Are you a smoker? How long: _____

Do you or have you ever suffered from high blood pressure: _____

Family History (Cancer, Diabetes, Heart Disease, Mental Health): _____

_____

_____

Sleeping Patterns: _____ _____

Do you drink Alcohol? How much: _____

Have you been treated for alcoholism: _____

Do you use recreational drugs: _____

Have you been treated for drug abuse? _____

Female Reproductive:

Length of cycle _____ days

Duration of Menses _____ days

Regularity of periods: _____

_____ _____

# of pregnancies:_____ # of miscarriages: _____

Discharges/Breakthrough bleeding: _____

Vaginal or uterine infections: _____

Menopausal Symptoms: _____