integrated health aus
combining traditional and modern medicine

Patient information **Date __/____/___**

Surname: _____ Given Names: _____

Date of Birth: ____/____/____ Age: _____ Sex: M or F

Address: _____ Suburb: _____ P/code: _____

Ph: _____ Bus: _____ Mob: _____ Email _____

Best contact for confirmation of appointments: _____ Text _____Call_____Email_____

Marital Satus: Single/Defacto/Married/Divorced/Widow: _____

Do you have any Children Y/N, If so how many? _____

Occupation: _____How long have you done this job? _____

How did you hear about the clinic/who where you referred by? _____

Who is your family GP?_____

Do you see any other health practitioners?: (chiropractor, Specialists etc): _____

Have you ever consulted with an Naturopath before, if so when? _____

Are you in a health fund if so which one which cover for Natural medicine ? _____

Are you Currently on Medication if so what type? _____

Supplements (vitamins, herbs etc) _____

Do you have any known Allergies? Y/N What type? _____

Why are you here today? _____

How long have you had this problem? _____

What makes symptoms better or worse? _____

Do you have any surgical scars if so where? _____

Have you moved into a new house or bought a new car recently?_____

Do you have any problems in any of the following areas? (please circle) Head, Eyes, Ears, Nose, Mouth, Throat, Chest & Respiratory Chest, Cardiac, Circulation problems, Muscles, Joints, Spine, Reproductive organ, Menstruation, Urinary bladder, Neurological (nerve) digestion, Bowel, gallbladder, kidneys, Liver	
Have you had any of the following diseases diagnosed? (please circle) Diabetes, Cancer, Heart disease, Arthritis, High /low blood pressure, HIV AIDS? Or other please specify: **Are any of the above diseases in your family? Y / N** Please specify**:**	
Breakfast:	
Morning tea:	
Lunch:	
Afternoon tea:	
Dinner:	
How Much Water do you drink?	**Tea or coffee?** Y / N **How much?**
Do you use recreational drugs/alcohol, cigarettes?	
Do you exercise? Yes/No Please specify what type how often?	
How much stress do you have? Scale of 1-10	
How is your sleep?	**How many hours ?**
How is your energy? Scale of 1-10	
What is your blood type ?	**Secretor status**

I hereby acknowledge that the information given above or in clinic is given to the best of my knowledge and that my personal health information is kept strictly confidential unless authorized otherwise. As a patient I also agree that it is my responsibility to give details as accurately as possible. I also agree to disclose information on previous and current illness. I understand that complementary medical practitioners provide health management based on correct information given***.***
I also understand that a cancellation fee applies for late cancellation (within 24 hours) or non-attendance as this may prevent others from receiving treatment.I also understand that it is my responsibility to record my appointment time and honor appointments

Signature_____ Date __/__/__ Print name_____