



**PATIENT INFORMATION – CONFIDENTIAL**

Date:.....

**PERSONAL DETAILS**

TITLE:.....SURNAME: ..... GIVEN NAME/S.....  
 DATE OF BIRTH: .../.../..... AGE: ..... SEX: M / F  
 MARITAL STATUS: ..... NO. OF CHILDREN: .....  
 ADDRESS: .....  
 PHONE NUMBER: (Home) ..... (Work) ..... (Mobile).....  
 EMAIL ADDRESS: .....  
 OCCUPATION: ..... EMPLOYER: .....  
 HEALTH FUND:.....  
 How did you become aware of this clinic? ..... Who can we thank for referring you here? .....  
 From time to time this practice sends out newsletters, birthday cards or clinic promotions, are you happy to receive these? [ ] Yes [ ] No  
 Do you wish to receive appointment reminders via SMS? [ ] Yes [ ] No

**CHIEF COMPLAINT**

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? .....  
 WHEN DID THIS EPISODE BEGIN?.....  
 HAS THIS OCCURRED BEFORE? ..... WHEN?.....HOW OFTEN?.....  
 WHAT CAUSED THIS PROBLEM? .....  
 IS THE PROBLEM GETTING WORSE, BETTER OR STAYING THE SAME? .....  
 IS THIS A WORKERS COMPENSATION OR TAC CLAIM? ..... CLAIM NUMBER: .....  
 “ I understand and agree that services rendered are charged directly to me and that I am personally responsible for payment, except where covered by Private Health Insurance.”  
 SIGNATURE OF PATIENT: ..... DATE: .....

**PREVIOUS TREATMENT**

NAME OF PRACTITIONER:..... DATE.....  
 TYPE OF TREATMENT: ..... DIAGNOSIS: .....  
 X-RAYS TAKEN: Y / N      RESPONSE TO TREATMENT: .....

**GENERAL PRACTITIONER DETAILS**

NAME OF PRACTITIONER:..... CLINIC NAME.....  
 ADDRESS: ..... PHONE:.....  
 Do we have your consent to communicate with your GP about your condition?      Yes / No



**HEALTH STATUS SCREEN**

**It is very important for us to know about any other health problems you may have, or have had in the past, as these can all contribute to your current condition.**

Please circle O any conditions or symptoms presently causing you problems.

Please tick ✓ those conditions or symptoms that have been a problem to you in the past.

<b>GENERAL SYMPTOMS</b>	<b>E.E.N.T</b>	<b>SKIN</b>
Numbness, pain or tingling	Asthma	Eczema
Loss of consciousness	Earache	Rashes, itching
Blackouts	Eye pain	Psoriasis
Headache	Ringing, buzzing, noise in ears	Bruise easily
Fever	Sinus infections	Dryness
Sweats	Hayfever	Boils
Fainting	Failing vision (one/both eyes)	Hives (allergy)
Dizziness	Crossed eyes	Recent changes in a mole/freckle
Clumsiness	Double vision	Acne
Convulsions	Deafness	
Loss of sleep	Blurred vision	<b>GENTOURINARY</b>
Nervousness	Frequent colds	Bed-wetting
Unexplained weight loss	Enlarged glands	Kidney infection
	Slurred or other speech problems	Frequent urination
<b>MUSCLE AND JOINTS</b>	Difficulty swallowing	Blood in urine
Stiff neck		Burning with urination
Backache	<b>RESPIRATORY</b>	Prostate trouble
Painful tailbone	Chronic cough	Trouble urinating
Hip pain	Chest pain	
Knee pain	Spitting up phlegm	<b>G.U FOR WOMEN</b>
Ankle pain	Spitting up blood	Cramps or backache
Foot trouble	Difficulty breathing	Painful menstruation
Shoulder pain	Tuberculosis	Irregular cycle
Arm/forearm pain		Hot flashes
Elbow pain	<b>GASTROINTESTINAL</b>	Excessive flow
Wrist pain	Indigestion	Vaginal discharge
Hand pain	Nausea	Swollen breasts
Swollen joints	Ulcers	Lumps in breast
Arthritis	Constipation	
Weakness or loss of strength	Diarrhoea	Have you ever been on
	Diabetes	Birth control pills?
<b>CARDIOVASCULAR</b>	Excessive hunger	Yes / No
High blood pressure	Belching or gas	
Pain over the heart or chest	Vomiting (blood?)	Are you currently taking birth
Angina	Pain over the stomach	control pills?
Hardening of the arteries	Hemorrhoids (piles)	Yes / No
Low blood pressure	Jaundice	
Bleeding disorder	Gall bladder problems	No. of pregnancies.....
Varicose veins	Intestinal worms	No. of children .....
Swelling of ankles	Poor appetite	
Poor circulation		
Stroke		