Personal, Work and Medical Information

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

Name: _____ Birth Date: _____
Sex: _____ Marital Status: _____
Address: _____
Home Phone: _____ Mobile: _____
Email: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____
Phone/Mobile: _____
How did you learn about the clinic: _____
Name of Doctor: _____ Contact: _____
Private Health Fund: _____

Cancellation Policy

If you need to cancel your appointment, I 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 client about them. These complications may include soreness, inflammation, dizziness, nausea, fatigue, change in bowel movements and headaches. These issues may arise due to detoxification, elimination of toxins and parasites and changes in diet. Energetic Therapies, such as acupuncture may move energy within the body and generally improvement is felt, however, in some cases it can detox the body and you may experience any of the above symptoms. If you need to know more about this process, please ask the practitioner for more information.

I have read and understood the above statements regarding these possible affects.

_____ _____ _____

Client/Guardian Signature **Relationship** **Date**

Medical History

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

_____

_____

_____

Surgical Procedures: _____

_____

_____

Childhood illnesses: _____

_____

Current Medications: _____

_____

Immunizations/Vaccinations: _____

_____

Do you have any allergies or suspect that you are allergic to certain foods/substances?

_____

_____

Are you aware or do suspect that you have been exposed to toxic substances in your home

or work environment? _____

_____

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

_____

Are you a smoker? How long? _____

Do you drink Alcohol? How much? _____

Do you or have you suffered from High Blood Pressure? _____

_____

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

_____

Sleeping Patterns: _____

Do you use recreational drugs? _____

Female Reproductive: Length of cycle? _____ Days Duration of menses? _____ Days

Regularity of periods? _____ Discharges/Breakthrough Bleeding? _____

Number of Pregnancies? _____ Miscarriages? _____

Menopausal Symptoms: _____