Initial Consultation Form

Welcome and thank you for choosing

CentralCity Health Professionals
Faster recovery & lasting results

Personal Details

Dr Mr Mrs Ms Miss Mast FIRST NAME SURNAME

Preferred Name (Nickname): [ ] Male [ ] Female

Date of Birth: Age:

Address: Suburb: P/Code:

Phone/Mobile: Email:

Occupation: Private Health:

Usual GP: Practice Name and address:

How did you hear about us?

[ ] Recommended or Referred [ ] Web site [ ] Google search [ ] Health Engine [ ] Street Signs

[ ] Flyer/Voucher/Magnet [ ] Walked Past [ ] Facebook [ ] Other – please specify

If Recommended or Referred, who may we thank?

Purpose of this Consultation

Please write here, what your ***main*** concern is:

Health History

Please tick if you have been previously diagnosed, or recently experienced, any of the following:

[ ] Arthritis	[ ] Diabetes	[ ] Gout	[ ] Fever	[ ] Osteoporosis
[ ] Asthma	[ ] Dizziness or Fainting	[ ] Cardiovascular Disease	[ ] Migraines	[ ] Stroke
[ ] Cancer	[ ] Epilepsy/Seizures	[ ] High / Low Blood Pressure	[ ] Psoriasis	[ ] Unexplained Weight Loss
[ ] Heart Disease	[ ] Chest Pain	[ ] Hypertension	[ ] Pacemaker	[ ] Pregnant
[ ] Smoker	[ ] Allergies/Sensitivities to tape, creams etc.		[ ] Bleeding disorders	

Have you had any major surgeries or serious illness? [ ] No [ ] Yes

If yes, please explain:

Have you had any recent x-rays or scans during the past year? [ ] No [ ] Yes

Are you receiving any other treatment at present? [ ] No [ ] Yes, please specify:

What medications and/or supplements are you currently taking? [ ] None

Are you participating in any exercise? [ ] No [ ] Yes, please specify:

Declaration

I hereby declare that: i) the information supplied is correct to the best of my knowledge; and ii) that all debts owed in relation to the provision of services are my responsibility.

Patient Signature: Date:

Parent / Guardian Signature: Date: