Hunter Health

TO BE COMPLETED BY ALL NEW CLIENTS TO HUNTER HEALTH

FIRST NAME: _____ LAST NAME: _____

ADDRESS: _____

CITY/TOWN _____ STATE: _____ POSTCODE _____

PHONE (H) _____ (W) _____ (M) _____

EMAIL: _____ D.O.B _____

OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US?

Doctor's Referral ☐ Internet ☐ Friend / Colleague ☐

Trainer / Other Health Professional ☐ Other ☐

Name of Referrer (if known) _____

Thank you for your payment at the time of consultation. Health Fund rebates can be claimed directly provided you carry your card with you. The gap in payment can be made using Cash, EFTPOS, Visa, Mastercard, or American Express.

Please be advised that unattended appointments and cancellations less than 24 hours before a scheduled appointment will incur the full fee.

SIGNED: _____ DATE: _____

Hunter Health Services

8.03/5 Hunter Street, Sydney NSW 2000 **P.** 02 9241 2876 **F.** 02 9232 7284

E: reception@hunterhealthservices.com.au **W:** hunterhealthservices.com.au

Hunter Health

MEDICAL HISTORY QUESTIONAIRE

(Confidential)

TO BE COMPLETED BY NEW OSTEOPATHIC CLIENTS ONLY

Are you currently seeing any of the following?

- ☐ Medical Doctor
- ☐ Osteopath
- ☐ Chiropractor
- ☐ Dentist
- ☐ Psychiatrist / Psychologist
- ☐ Massage Therapist
- ☐ Physiotherapist

Have you ever been diagnosed with any of the following?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ Chemical dependency (eg alcoholism)
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Other arthritis
- ☐ Depression
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Kidney disease
- ☐ Anaemia
- ☐ Epilepsy
- ☐ Other _____
- ☐ Other _____

Has anyone in your family been treated for any of the following?

- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Kidney disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Anaemia
- ☐ Headache
- ☐ Epilepsy
- ☐ Mental illness (eg depression)
- ☐ Chemical dependency (eg alcoholism)

Are you (or do you believe you are) currently pregnant?

- ☐ Yes
- ☐ No

Have you experienced any of the following in the past four weeks?

- ☐ Fever / chills / sweats
- ☐ Unexplained weight change
- ☐ Excessive tiredness
- ☐ Nausea / vomiting
- ☐ Bowel dysfunction
- ☐ Numbness
- ☐ Weakness
- ☐ Dizziness / light-headedness
- ☐ Passing out
- ☐ Night pain
- ☐ Shortness of breath
- ☐ Urinary frequency changes
- ☐ Sexual dysfunction

Which of these over the counter medications have you taken in the past week?

- ☐ Aspirin
- ☐ Antinflammatories (eg neurofin, ibuprofen, advil)
- ☐ Glucosamine and chondroitin
- ☐ Laxatives
- ☐ Decongestants
- ☐ Antihistamine
- ☐ Antacids
- ☐ Vitamins / mineral supplements
- ☐ Other _____
- ☐ Other _____

Please list any prescription medicines you are taking (include pills, injections, patches)

_____

_____

_____

Please list any previous injuries for which you have been treated, including the approximate date of injury:

_____

_____

_____

_____

_____

_____

_____

Please list any surgery you have undergone, including the approximate date:

_____

_____

_____

_____

_____

_____

SIGNED: _____ DATE: _____

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