Intake form

Personal Information

None

Jobe	Middle Name
Kobe	123456789456
Ph: Work	Ph: Home
admin@yourhealthyourchoice.com.au	01/01/1970
Address	Lawn mower

Male | Female | Other

Emergency contact

First Name	Last Name
Mobile phone	Relationship

Referral source

How did you hear about this clinic?

Family or Friends — Claudia Patient

Health History

If you have a history of any of the following conditions, please select below.

☑ Heart disease	☑ Diabetes	☐ Asthma
☑ Severe weight loss/gain	☐ Headaches	☐ Autoimmunity
☐ Dizziness	☐ Pregnant	☐ Cholsesterol
☐ Severe fatigue	☐ Blood pressure	☐ Night sweats
☑ Skin conditions	☐ Epilepsy	☐ Thyroid
☑ Deleted HIV	☑ Deleted bruise easily	☑ Added this

Health history details

A

Surgeries

B

Medicines/Supplements

C

Alcohol consumption

D

Smoking

E

Family history

F

Turned off exercise

G

Added second box

H

Currrent complaint

Please provide more information about your current condition.

When did the problem begin?	Monday
What caused the problem?	Tuesday
What relieves your symptoms?	Wednesday
What aggravates your symptoms?	Thursday
Deleted what are the reasons for your visi today	Friday
Adede tell me why you're here	Saturday

Immune system

Please answer the following questions

Q1	Yes / No
Q2	A
Q3	Yes / No
Q4	B

Second section

intro text

Q1	A
Q2	B
Q3	C
Q4	D

Upload files

Please upload any files such as test results or x-rays that you wish to share with your service provider.

List of test results

2021-06-17 | This should be the only test result

Private Health Insurance

If you have private health insurance that covers you for natural therapies, please provide your details below.

Health Fund

Fund name: added 17/6/21

Card Number: 23423411111

Issue Date: 04/02/2020

Number on card: 2

Update

Consent

I have to the best of my knowledge, provided all relevant information about my health and medical history and i give my full consent to treatment. I intend this consent to apply to all future treatments and understand that I must update my service provider with any changes that may occur in my medical history. I understand that a 50% cancellation fee may apply if I do not provide at least 24 hours notice.

- ☑ I consent to treatment
- ☑ I consent to receiving correspondence via SMS and/or email from my service provider

Name

Type full name

Download