Personal Information

none

newclient

Middle Name

two

57439865555

Ph: Work

Ph: Home

newclienttwo@yopmail.com

11/11/1995

Address line 1

Occupation

Male Female Other

Emergency contact

First Name

Last Name

Mobile phone

Relationship

Referral source

How did you hear about this clinic?

Family or Friends

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
- [ ] Cholesterol
- [ ] Severe fatigue
- [ ] Bruise easily
- [ ] Blood pressure
- [ ] Night sweats
- [ ] Skin conditions
- [ ] HIV
- [ ] Epilepsy
- [x] Thyroid

Medicines/Supplements

Alcohol consumption

Smoking

Excercise

Family history

TEST1

TEST2

Currrent complaint

Please provide more information about your current condition.

What is the reason for your visit? _____

When did the problem begin? _____

What caused the problem? _____

What relieves your symptoms? _____

What aggravates your symptoms?

Lfgnlfnglfnhgfh;lfgm;lhmfg;h

oifgjhfgjhfgjhfghjfghjfg

lnlnfnhnfghnfgknghfgn

Yes No

12

13

14

Yes No

Hello hader

hello into text

hello 1

Yes No

hello 2

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

2021-07-26	test result four
2021-07-26	test result three
2021-07-26	test result two
2021-07-26	test result
2021-07-23	fsdfsdf
2021-07-22	newclient

Private Health Insurance

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

Health Fund

Fund name

Card Number

Number on card

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.

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

Name

test