Personal Information

none

Patient

Middle Name

Mahmadul

Mobile phone

Ph: Work

Ph: Home

testerbd365+test04@gmail.com

08/09/2000

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
- [ ] Thyroid
- [ ] test

Health history details

Low

Surgeries

Heart

Medicines/Supplements

SMC

Alcohol consumption

Yes

Smoking

yes

Excercise

No

Family history

Hot Blooded

Currrent complaint

Please provide more information about your current condition.

What is the reason for your visit?	QA testing
When did the problem begin?	QA testing
What caused the problem?	QA testing

What relieves your symptoms? QA testing

What aggravates your symptoms? QA testing

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.

I consent to treatment

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

Name

MH