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: