healthspace New Client Form

ADMIN USE:
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WELCOME TO HEALTH SPACE AND THANK YOU FOR CHOOSING US!

DATE: 1 / 1 / 1900

☐MR ☐MRS ☐ MS ☐DR GIVEN NAME: SURNAME: GENDER: M

ADDRESS: SUBURB & POSTCODE

Phone: HOME MOBILE WORK

D.O.B.: 1 / 1 / 1900 EMAIL:

OCCUPATION: PARTNER NAME:

PREGNANT? YES NAMES & AGES OF CHILDREN:

PRIVATE HEALTH FUND: MEDICARE NUMBER:

GENERAL PRACTITIONER:

GP ADDRESS: GP PHONE NUMBER:

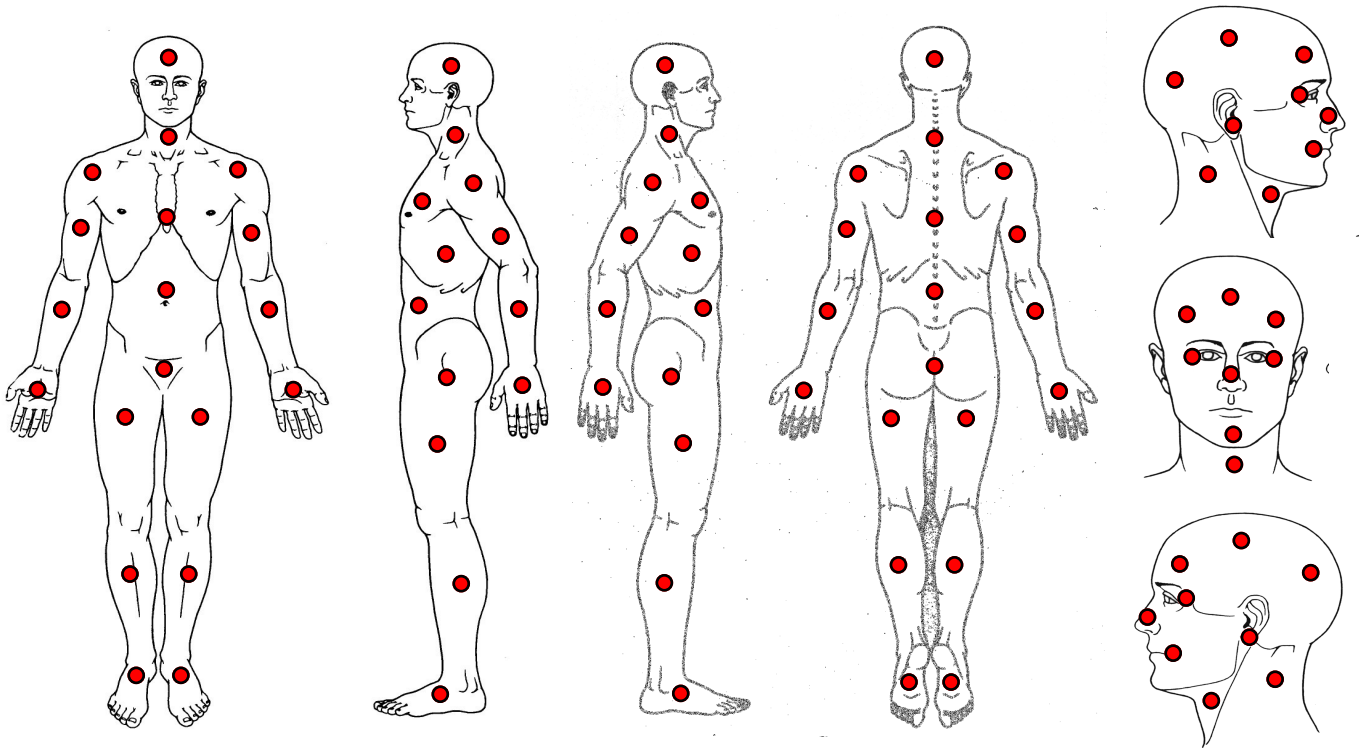
Who can we thank for referring you to Health Space?

Please tell us about any past or present treatment and experiences with Natural Health Care Practitioners:

Addressing any health concerns you have:
*If you have no symptoms or complaints and are here for to enhance your general health and well-being, please skip to the **"General Health History"** on page 2.*

Please list your health concerns	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	Have you had this Condition before, When?	Do you know what caused the problem?
1.	1			
2.	1			
3.	1			

Please mark on the diagram below where you are experiencing any discomfort or pain, or have an injury:



Describe your pain, is it dull, sharp etc? Does it radiate anywhere? If so, where?

Since the problem started, is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

Which activities aggravate your condition?

Have you seen any other doctors or practitioners for this condition?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc.? (i.e. eat better, less alcohol/drugs, meditate or breathe more, less destructive sports/activities, etc.) If so, what?

Is this condition interfering with any of the following?

☐ Work	☐ Sleep	☐ Daily Routine	☐ Sports/Exercise	☐ Other (please explain):

GENERAL HEALTH HISTORY

Accumulation of life's 'stressors' often lead to health problems and may influence your ability to heal. Please be as specific as you can in this section so we have as much information as possible in order to help you.

Have you had surgery? (Please include ALL surgeries)

1. Type: When?

2. Type: When?

Do you wear, or have you ever worn, orthotics or heel lifts? YES Explain:

Have you had any imaging done of your body (scans, X-rays, MRI's)? If yes, please list the body part and type of imaging done:

What Blood Type are you? O-

Do you have any food cravings?

Do any foods /beverages cause you discomfort?

How many bowel movements do you have a day?

I smoke cigarettes per Day I drink alcoholic drinks per Day

I drink coffees per Month I drink litres of water per Month

Are you allergic to any essential oils? YES If yes, which ones?

Do you like / dislike any essential oils? Please give details

What is your preferred pressure for soft tissue work? Light? ☐ Medium? ☐ Deep? ☐ Extra Deep? ☐

On a scale of 1—10, (1 being poor and 10 being excellent), please rate your current (please circle):

Energy Levels	1	Mood	1
Ability to exercise	1	Posture	1
Immune function	1	Concentration	1

SYMPTOM SURVEY—We need a complete view of your health to give you the best care:

Digestion & Elimination		Respiratory	
☐ Abdominal Bloating	☐ Nausea / Vomiting	☐ Asthma	☐ Tight Chest
☐ Constipation	☐ Abdominal Pain	☐ Coughing	☐ Shortness of breath
☐ Loose Stools / Diarrhoea	☐ Excessive belching / flatulence	☐ Phlegm / chest congestion	☐ Wheezing

Musculo-Skeletal

- ☐ Muscle Pain
- ☐ Joint pain
- ☐ Muscle tension
- ☐ Arthritis
- ☐ Neurological disorder
- ☐ Low back pain
- ☐ Broken bone
- ☐ Osteoporosis
- ☐ Muscle weakness
- ☐ Muscle cramping
- ☐ Poor Flexibility
- ☐ Spinal disc injury
- ☐ Mid back pain
- ☐ Sciatica

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Bruising easily
- ☐ Chest pain
- ☐ Cold hands and feet
- ☐ Varicose veins
- ☐ Fainting

Dental

- ☐ Amalgam fillings
- ☐ Root Canal Therapy
- ☐ Braces
- ☐ Jaw issues / pain

Female Reproduction

- ☐ Irregular period
- ☐ Period pain
- ☐ Heavy periods
- ☐ Light periods
- ☐ Blood clots
- ☐ Miscarriage
- ☐ PMT
- ☐ Low libido
- ☐ Poor fertility
- ☐ Menopausal symptoms
- ☐ Short or long cycle
- ☐ Still–birth

Male Reproduction

- ☐ Low libido
- ☐ Impotence
- ☐ Poor fertility
- ☐ Low sperm count
- ☐ Low sperm mobility

Skin

- ☐ Eczema / Dermatitis
- ☐ Psoriasis
- ☐ Acne
- ☐ Dry Skin

Stress & Emotions

- ☐ Anxiety
- ☐ Depression
- ☐ Easily angered
- ☐ Irritable
- ☐ Worry / Over-thinking
- ☐ Insomnia / Poor sleep

Thirst & Urination

- ☐ Excessive thirst
- ☐ No desire to drink
- ☐ Frequent urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Dribbling urine / Incontinence

Head & Throat

- ☐ Headaches
- ☐ Dizziness
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Ringing in the ears
- ☐ Migraines
- ☐ Poor hearing
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Sinus / Nasal congestion
- ☐ Hayfever

General Health

- ☐ Fatigue
- ☐ Frequent colds / flu
- ☐ Feel hot easily
- ☐ Feel cold easily
- ☐ Poor mental clarity
- ☐ Unusual sweating
- ☐ Oedema / Swelling
- ☐ Numbness / Tingling
- ☐ Gain weight easily
- ☐ Lose weight easily

Conditions

- ☐ Adrenal problems
- ☐ Alcoholism
- ☐ Allergy
- ☐ Anaemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Cold Sores
- ☐ Convulsions
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fainting
- ☐ Gall Bladder Problems
- ☐ Gout
- ☐ Heart Attack / Disease
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Whooping Cough

Other (please explain)

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SLEEP AND ENERGY OVERVIEW:

How many hours sleep do you average per night? | Do you wake up during the night? YES | What time usually?

Do you have difficulty falling asleep? NO

Sleep Quality: LIGHT | Do you awake: REFRESHED

Rate your general energy levels during the day from 1—10 (1 being low and 10– being high): 1

Do you have any energy slumps during the day? YES | At what time of day?

Do you like exercising? YES | What is your favourite type of exercise?

Please list the type of exercise you do and how often?

DIET AND NUTRITION OVERVIEW:

Please give us an overview of your current diet:

Breakfast

Lunch

Dinner

Snacks

Do you have any food allergies and intolerances?

Do you have any special dietary requirements?

CURRENT MEDICINES & SUPPLEMENTS:

Please list any medications/drugs you have taken in the past six months and currently and why: (prescription and non-prescription)

Please list any nutritional supplements, vitamins, homoeopathic remedies you presently take and why?

Do you take the Contraceptive pill? NO | If yes, please list which one, and for how long?

STRESSORS:

Because accumulation of stress affects our health and ability to heal, please list your top two stresses (that you have ever had) in each category below:

1. Physical Stress (falls, accidents, work postures, etc.)
   - A.
   - B.
2. Bio-chemical Stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   - A.
   - B.
3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   - A.
   - B.

On a scale of 1-10 (1 being poor and 10 being excellent), please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: 1	At home: 1	At play: 1

GOALS:

What are your short term health goals?

What are you long term health goals?

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CONSENT:

Many of the clients at Health Space utilise a variety of services, so to save you time and make it easier for the practitioners to communicate about your case we have one form for all therapies. Please read through and sign that you have read and consented to all the waivers below so you don't have to fill out anymore paperwork again. We appreciate the time you have taken to give us your detailed information so we can now do our best to help you!

24 hours notice is required to cancel or reschedule any new client appointment. We allow extra time for new clients, and have a wait list, so please give us notice so your appointment can be utilised if you can't make it.
Ongoing appointments, 24 hours notice must also be given if you are changing any scheduled appointments, except for Chiropractic which requires 6 hours notice.

Chiropractic

At Health Space we aim to provide the highest quality care. Part of this care may involve cervical (neck) manipulation. We feel it is important that you are aware that as with any healthcare procedure there is some risk associated with cervical manipulation. The risk is currently estimated at 1 in 1,000,000 for stroke or stroke like symptoms. This is a rare and unpredictable event. Other risks that can be associated with spinal adjustments include disc injuries, rib fractures, sprains/strains or pre-existing conditions may be aggravated. We take every precaution to ensure that this risk is minimised through thorough testing, examination, and the use of gentle and specific techniques. If you have any concerns, please let your Chiropractor know.
I acknowledge that I have been informed of the risks involved and understand that if at any time I have concerns, these can be discussed with my Chiropractor. I appreciate that I will receive the best care possible at Health Space but that results cannot be guaranteed. I consent to a professional and complete Chiropractic examination and to any radiographic examination that the doctor deems necessary and i agree to follow recommendations unless I say otherwise.

Acupuncture

I consent to receive Chinese medical treatment at Health Space, which may include herbal remedies, acupuncture and other manual therapies. I understand there is some risk associated with Chinese medical treatments. These risks include bruising, bleeding, pain, burns, skin infections, allergic reactions, interactions with medication and temporary worsening of symptoms. To avoid these risks I will answer all health questions fully and will notify my practitioner of all allergies I have and medication I am taking.

Massage

I understand that the massage I receive at Health Space is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medication and does not perform spinal manipulation. If I experience any pain or discomfort during or after the session, I understand it is my job to immediately inform the therapist so the treatment can be adjusted. I have informed the massage therapist of all my known physical conditions, medical conditions and medications. I will keep the massage therapist updated on any changes in my medical profile and I understand that there shall be no liability on the massage therapist's part should I fail to do so.

Nutrition / Naturopathy / Kinesiology

I understand that the Nutritionist / Naturopath / Kinesiologist does not diagnose illness or disease. I understand that non invasive and natural methods are used in the assessment and treatment of any dysfunctions. I understand it is my duty to give an accurate personal health history and I consent to the use of diagnostic equipment and muscle testing to be performed on me after it has been thoroughly explained by the treating practitioner. I understand that I am able to ask questions at any time and must let my practitioner know of any changes that I make or plan to make (or not make) in regards to previous or current health recommendations.

Reflexology:

By signing this form, I give my consent to have reflexology treatment at Health Space. I understand I may discontinue the treatment at any time. If I have been diagnosed by a licensed health professional as having any disease, injury or other physical or mental condition, I understand that I should inform the person who made the diagnosis about the reflexology treatments I will be receiving, and whether or not I intend to discontinue any treatment or therapy which has been previously ordered, prescribed or recommended by a licensed health professional. I understand that by discontinuing any such treatment or therapy, I assume responsibility for any negative outcome resulting from discontinuing that treatment or therapy.

I understand that if I don't give the necessary notice if I need to change a scheduled appointment that a cancellation fee will apply of 50% of the consultation charge.

Client Signature: _____ Date: 1 / 1 / 1900

Your information is private and confidential, however we may need to correspond with various third parties, including your GP, Specialist or insurance company with your permission.

Health Space provides an appointment reminder service by email and may also communicate with you by SMS and email from time to time. This includes a free monthly newsletter with recipes, deals and clinic updates.

All clients are automatically enrolled in this service. If you do not wish to have this service please indicate below:

☐ Please do not send me appointment reminders and the monthly newsletter by email.