PERTH WELLNESS CENTRE

PERTH WELLNESS CENTRE
PATIENT INFORMATION

Date:

Name: ______________________________ (FIRST) ______________________________ (SURNAME) DOB: __________

Address: ____

Phone Home: __________ Mobile: __________ Work: __________

Email: ____

Occupation: ______________________ Employer: __________

Marital status: ______________________ No. Children: __________

Health Cover: ☐ Self ☐ Private Insurance ☐ Motor Vehicle ☐ Worker's Comp

Who recommended us? ☐ Google/Web ☐ Patient/Friend (Name:____________________)

☐ Practitioner ☐ Yellow Pages ☐ Other

Fees are paid on the day of service. All patients are required to pay 50% of their consultation for all appointments missed without 24hrs notice.

DO YOU UNDERSTAND WHAT WELLNESS CARE IS? Circle Y / N

The human body is designed to be healthy.This case history will uncover layers of damage that have reduced function and produced poor health. Following your exam, a course of care will be outlined to correct these layers of damage and restore your health.

Please list main concerns: ______________________

____

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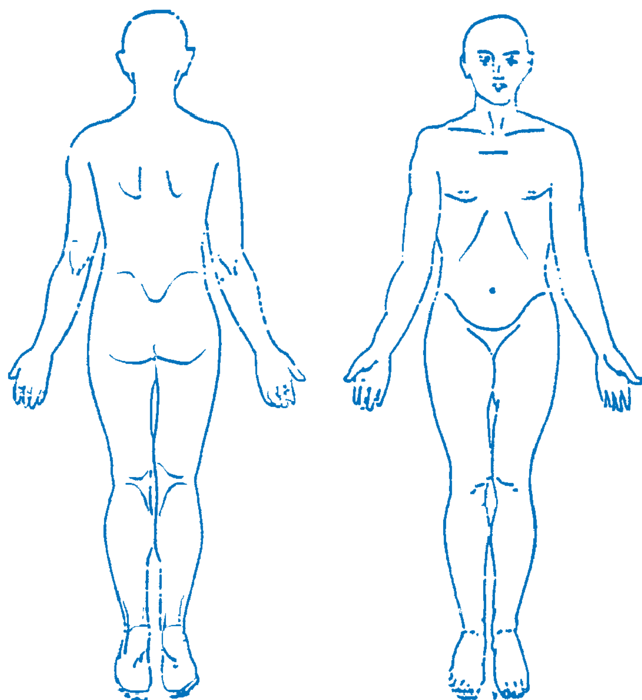
Circle area/s of concern



How and when did your condition start? ______________________

____

Grade your symptoms (if any) on a scale of 1-10.

0 ______________ 5 ______________ 10
nil moderate severe

Do you feel you are:

☐ improving ☐ deteriorating ☐ static

Please describe your symptoms:

____

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____

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____

____

Have you experienced any of the following in the last week?

☐ Double Vision ☐ Dizziness/Vertigo

☐ Drop Attacks ☐ Speech problems

☐ Difficulty Swallowing ☐ Difficulty walking

☐ Nausea ☐ Numbness on one side

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Health History

Have you had any childhood diseases? ☐ Yes ☐ No

List significant falls or accidents (please describe).

List all operations/hospitalisations/serious illnesses.

List medications (prescription & non-prescription).

In the past 24 months have you experienced:

☐ recurring fever ☐ weight loss ☐ night pain
☐ anxiety/tension ☐ depression ☐ hypertension
☐ family dislocation ☐ job loss ☐ blackouts

Is there a family or self history of:

☐ stroke ☐ obesity ☐ osteoporosis
☐ cancer ☐ Alzheimer's ☐ eating disorder
☐ heart attack ☐ diabetes ☐ immune deficiency?

Are you pregnant? Or think you might be? ☐ Yes ☐ No

Are you suffering from any of the following?

Mark the appropriate boxes with **O** - Occasionally, **F** - Frequently, **C** - Constantly or leave blank if not applicable.

☐ Nervousness
☐ Chronic irritability
☐ Insomnia
☐ Scalp ache
☐ Head/face pain
☐ Headache
☐ Dizziness
☐ Nausea/vomiting
☐ Loss of concentration
☐ Eye disorder
☐ Sinusitis
☐ Hay fever
☐ Loss of taste/smell
☐ Chronic cough
☐ Asthma
☐ Food allergies
☐ General swelling
☐ Neck pain/symptoms
☐ Shoulder pain
☐ Arm/elbow pain
☐ Arm weakness
☐ Hand/wrist pain
☐ Finger numbness
☐ Blood pressure
☐ Chest pain
☐ Shortness of breath
☐ Indigestion
☐ Ulcer
☐ Heartburn
☐ Mid back symptoms/pain
☐ Rib pain
☐ Constipation
☐ Diarrhea
☐ Abdominal pain/cramping
☐ Kidney disorder
☐ Urinary problems
☐ Menstrual disorder
☐ Testicle pain
☐ Impotency
☐ Other sexual disorder
☐ Low back pain
☐ Buttock pain
☐ Hip joint stiffness
☐ Leg pain
☐ Leg weakness/numbness
☐ Knee problems
☐ Calf cramping
☐ Ankle swelling
☐ Ankle/foot weakness
☐ Foot/toe numbness
☐ Skin problems

Financial Responsibility

I acknowledge that payment is due on the day of service. I understand that a fee of 50% of my consultation will be incurred for all cancellations made (without valid reason) without 24hrs notice.

Signature: ______________________ Date: __________

OUR GOAL FOR YOU ➜ REDUCED PAIN + IMPROVED FUNCTION = A BETTER LIFE