

**Getting to know you form**clinic@thebodyguard.com.au

07 3151 2183 - 0421 379615

Welcome to The Body Guard clinic. We require this information to provide you with the best quality comprehensive care. Our clinic follows the guidelines of best practice for the management of health information in private practice. This means your personal health information is kept private and secure as required by federal and state privacy laws as well as per the guidelines set out by the Australian Natural Therapy Association of Australia.

Your details			
Title	First Name		Surname
Date of Birth	/ /	Age	(Circle) Gender: M/F
Country of Birth	Occupation		Tasks
Have you ever worked with any appreciable exposure to any chemicals? Yes / no If yes, when? _____ How did you react? _____			
Have you ever worked on farms? Yes / No. Do you spray chemicals on your garden? Yes / No.			
Referred or recommended by:-			
Address:			
Email:			
<i>This is so we can contact them to thank them for the referral</i>			
Your contact details			
Home Address			
Suburb		State	Postcode
Ph.(Mobile)	Ph.(Home)		Ph.(W)
E-mail			
Relationship Status			
<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> De Facto	<input type="radio"/> Separated
<input type="radio"/> Divorced	<input type="radio"/> Widowed		
Number of Children & ages:-			
Emergency Contact Details			
Name		Relationship To You	
Ph.(Mobile)	Ph.(Home)		Ph.(W)
Vital Statistics (if known)			
Weight:	Height:	Waist:	Blood Type:
Contact Lenses: Yes/No			
Immunisations (please tick relevant boxes)			
<input type="checkbox"/> Pneumonia	Date:	<input type="checkbox"/> Influenza	Date:
<input type="checkbox"/> Tetanus	Date:	Other	

Your Health History		
Please list your current and regular medications including prescription, over the counter medications, vitamins and herbal medicine below. Please use additional sheets if required:-		
Name	Mg/day	Reason Prescribed or taking
Have you had any specialist consultations in the last 12 months? If yes, please specify & why		
Please advise of any pathology tests performed in the last 12 months and the results		
(Where possible please provide copies of the test results)		
Please list any known allergies and intolerances to medications, herbs or foods etc		
Please list any medical history and past surgery/operations and previous illnesses/injuries		
Women's Health		
Last Pap Smear	/ /	Last Mammogram / /
Men's Health		
Last prostate check (if aged over 40)	/ /	Result of prostate check:
Smoking History		Alcohol
<input type="checkbox"/> Never		<input type="checkbox"/> Non Drinker
<input type="checkbox"/> Former smoker – quit / /		<input type="checkbox"/> 1/day <input type="checkbox"/> 2/day <input type="checkbox"/> 3+/day
<input type="checkbox"/> Current smoker - /day		<input type="checkbox"/> 4+ at one sitting <input type="checkbox"/> once/week <input type="checkbox"/> once/month
<input type="checkbox"/> Number of years smoking		<input type="checkbox"/> 5+ at any one sitting

Please list any other recreational drug use. E.g marijuana, cocaine, speed, ice, ecstasy etc.

Please note your answers will remain confidential

Name of Drug	Date last used

Please indicate whether you have experienced any of the following conditions

<input type="checkbox"/> High BP	<input type="checkbox"/> Fluid Retention	
<input type="checkbox"/> Low Bp	<input type="checkbox"/> Dizziness	
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Fainting	<input type="checkbox"/> Problems with any organs Please state:-
<input type="checkbox"/>	<input type="checkbox"/> Menstrual Pain	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Reproductive problems
<input type="checkbox"/> Respiratory illness	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pregnant How many weeks:-
<input type="checkbox"/> Constipation	<input type="checkbox"/> Sciatica/lumbago/backpain	
<input type="checkbox"/> Thrombosis/circulatory conditions	<input type="checkbox"/> Cancer - Type:- Please state type:-	<input type="checkbox"/> Unable to conceive
<input type="checkbox"/> Haemophilia/bruising	<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Stroke	<input type="checkbox"/> Joint pain/discomfort	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Stress	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Skin allergies	<input type="checkbox"/> HIV Positive/Aids	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Airborne Allergies	<input type="checkbox"/> Hear voices
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Heart Burn/reflux	<input type="checkbox"/> Fatigue
<input type="checkbox"/> CFS (Chronic Fatigue Syndrome) Date diagnosed:-	<input type="checkbox"/> Sleep Apnea Date diagnosed:-	

Do you have any other diseases or conditions that you are aware of? Yes ☐ No ☐

If yes, please list:

Private Health Insurance

Do you have private health cover? Yes/No

Name of Insurer:-

You will be invoiced for your appointment. Payment is COD by direct deposit. A receipt will be issued when the payment is received.

FAMILY HISTORY

Please note if either you or any of your family have ever suffered from any significant medical problem please. If possible, note the age of onset of cardiac events and type of cancer, arthritis or allergy. Otherwise simply tick.

	Self	Father	Paternal Grand Father	Pat. Grand Mother	Father's Siblings	Mother	Maternal Grand Father	Mat. Grand Mother	Mother's Siblings	Your Siblings	Your children
Alcoholism											
Allergies											
Anxiety											
Asthma											
Arthritis											
Bowel Disease											
Cancer											
Dementia											
Depression											
Diabetes											
Epilepsy											
Gall Stones											
Heart Attack											
Hypertension											
Osteoporosis											
Parkinson's											
Schizophrenia											
Stroke/TIA											
Thyroid disease											
Other											

PAST MEDICAL HISTORY

As a child, did you significantly suffer from any of the following? (please tick)

	<input checked="" type="checkbox"/>	Age		<input checked="" type="checkbox"/>	Age
Asthma or Bronchitis			Colic		
Recurrent middle ear			Constipation		
Grommets			Diarrhoea		
Recurrent tonsillitis			Thrush		
Eczema			Irritability/crying		
			Febrile convulsions		

Until what age were you breast fed? _____

Health Support Team		
Doctor's name		
Doctor's phone no.		
Doctor's email address		
Other Health Care Professionals Currently Consulting (eg, counselor, specialist, chiro etc)		
Name	Field	Contact
Feedback		
How did you find out about The Body Guard (please tick)		
<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> White Pages	<input type="checkbox"/> Press
<input type="checkbox"/> Relatives	<input type="checkbox"/> Signage	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Workshops	<input type="checkbox"/> Leaflets/flyer	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> School newsletter	<input type="checkbox"/> Notice board	<input type="checkbox"/> Search Engine
<input type="checkbox"/> ANTA website	<input type="checkbox"/> ATMS website	<input type="checkbox"/> Business Breakfast
<input type="checkbox"/> Search Engine	<input type="checkbox"/> Link from other website	<input type="checkbox"/> Email
<input type="checkbox"/> Other (please specify)		

Would you like to receive our newsletter by email? Yes/No

STUDENTS
The Body Guard Clinic is involved in training the next generation of naturopaths and accepts students. Would you be agreeable to a silent student in attendance during your appointments? Some patients agree, some don't. We are fine either way and please don't feel any pressure.
I agree to a silent student in attendance. Yes/No

Privacy Patient Information

To provide a high standard of health care we need to collect personal information from our patients. This information is usually collected from the patient, but can also be collected from family members and other health care providers. At times some of this information needs to be shared with other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your clinician.

Consent

We ask for consent to discuss your case with your other health care providers should that be required to assist in your treatment.

I (Name)

Of.....(address)

consent to the use of my personal health information by **Christine Barnes of The Body Guard Clinic** and other health providers involved in my medical treatment and health care.

I consent to the disclosure of my personal health information by the above named practice to other health providers directly or indirectly involved in my personal health care or medical treatment.

Signature of patient or guardian.....

Please print name.....

Date.....