Fresh Holistic Health
INTEGRATIVE MEDICINE AT ITS BEST!

PATIENT DETAILS FORM

Title : Miss Ms Mrs Mr Dr Mast Other *(please circle)*

Family Name : _____ **Given Name :** _____ **Preferred Name :** _____

Date of Birth : _____/_____/_____ **Sex : Male / Female**

Ethnicity : _____ **Aboriginal & Torres Strait Islander** ☐
Aboriginal ☐
Torres Strait Islander ☐

Address : _____ **P'code**_____

Postal Address : As Above? ☐ _____ **P'code**_____

☐ **Home :** _____ ☐ **Work :** _____ ☐ **Mobile :** _____

Email : _____

☐ **Consent to SMS/Email/Newsletter?**

Occupation : _____

Medicare Number : _ _ _ _ - _ _ _ _ _ - _ **Patient No.** ☐ **Expiry** ____/_____

Pension / Health Care Card *(please circle)* **Number :** _____ **Expiry** ___/____/_____

DVA Card Gold/White Card *(Please circle)* **Number** : _____ **Expiry** ____/____/_____

Private Health Insurance Fund : _____ **Health Fund Number :** _____

Next of Kin Information/Emergency Contact : Name: _____

Relationship to patient : _____ **Home:** _____ **Mobile :** _____

Address : Same as yours? ☐ _____ **P'code**_____

Please tick which services you may be interested in and/or request more information on:

☐ Yoga/ Pilates/ Qigong/ Nia Dance ☐ Dietary requirements/cooking guidance ☐ Naturopathy

☐ Psychology ☐ Physiotherapy ☐ Counselling ☐ Osteopathy ☐ Regular health workshops

☐ Other _____

How did you hear about our Clinic? ☐ Website ☐ Social Media ☐ Kunara Customer ☐ Signage

☐ Magazine _____ ☐ Advertisement/Brochure ☐ Word of Mouth Other : _____ *(Please specify)*

This practice is a holistic health centre that cares for your overall health.

Your privacy is important to us. Fresh Holistic Health has policies in place to protect your privacy. We have many health professionals such as general practitioners, specialists and allied health professionals that use and have access to our electronic patient records. Because of the sensitive nature of the information collected by us to provide these services, extra precautions are taken to ensure the security of that information. Our electronic files are password-protected on several levels, and the computer backup tapes are stored offsite. We require all our employees and contractors to observe obligations of confidentiality in the course of their employment/contract.

As a patient of this clinic, we will contact you for recalls and investigation results.

This Practice is a private billing practice, by signing this form you are agreeing to pay accounts at the time of service.

Signature of patient or guardian: _____ **Date:** _____

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PATIENT REGISTRATION and MEDICAL HISTORY

What are your main goals/ health concerns?

Please fill in the following: Height: _____ Weight: _____ Waist Measurement: _____

How frequently do you exercise or engage in physical activity? _____

What sort of exercise do you enjoy? _____

Do you have any Allergies?

ALLERGY	REACTION

Please list any Regular Medications including over counter/vitamins/minerals/supplements:

MEDICATION	FREQUENCY

What prior experiences have you had with alternative medications?

Do you have or have you had a history of:

(Please include date of onset if appropriate)

- ☐ Heart Disease _____
- ☐ Diabetes
  - ☐ Type 1 _____
  - ☐ Type 2 _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Stroke _____
- ☐ Thyroid Disorders _____
- ☐ Chronic bronchitis/emphysema _____
- ☐ Asthma _____
- ☐ Bowel Problems /polyps _____
- ☐ Kidney Problems _____
- ☐ Arthritis _____
  - ☐ Type _____
- ☐ Tumours or Cancer _____
- ☐ Skin Problems _____
- ☐ Depression/anxiety _____
- ☐ Other Mental Illness _____
- ☐ Sleep Apnea _____
- ☐ Prostate enlargement _____
- ☐ Epilepsy _____

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Have you had any Operations?

Details/Date:

Family History-Have any members of your family been diagnosed or suffered from (List relation):

☐ Heart Disease	_____	☐ Arthritis	_____
☐ Diabetes (Type 1)	_____	☐ Kidney Problems	_____
☐ Diabetes (Type 2)	_____	☐ Tumors or Cancer	_____
☐ High Blood Pressure	_____	☐ Stroke	_____
☐ Thyroid Disorders	_____	☐ Skin Problems	_____
☐ Asthma	_____	☐ Depression/anxiety	_____
☐ Chronic bronchitis/emphysema	_____	☐ Other Mental Illness	_____
☐ Bowel Problems /polyps	_____	☐ High Cholesterol	_____
☐ Epilepsy	_____		

Social History:

Smoking History ☐ Never Smoked ☐ Current non smoker ☐ Smoker - Number per day_____

Do you drink alcohol ☐ No ☐ Yes - Number of standard drinks per week _____

Females: When did you last have: Pap Smear _____Mammogram _____Skin check _____

Males: When did you last have: An overall checkup _____Skin check_____

For those over 65 years and older:

When was the last time you were immunised – Influenza_____Pneumococcal _____

PATIENT NAME: _____